

# Extending the Medicare Prospective Payment System to Posthospital Care

## Planning a Demonstration

C. R. Neu, Adele Palmer,  
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Prepared for the  
Health Care Financing Administration,  
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**Rand/UCLA Center  
for Health Care  
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## PREFACE

In view of the apparent initial success of the Medicare hospital prospective payment system (PPS) in slowing the rate of increase in Medicare outlays for hospital care, some observers have suggested extending the system to include the posthospital care provided to Medicare patients by skilled nursing facilities and home health agencies. It is hoped that such an extension would not only help contain the costs of the Medicare program but would also improve access to posthospital care for Medicare patients.

The Rand Corporation was asked to assist the Office of Demonstrations and Evaluations, Health Care Financing Administration (HCFA), in planning a demonstration of an extended prospective payment system. This report collects in one place discussions of the nature of an extended PPS, of its potential benefits, and of how reimbursement rates might be set. It also addresses how a demonstration could be mounted, what could be learned from it, who would have to participate in it, and how demonstration sites might be chosen.

The report is intended to aid HCFA in deciding whether to proceed with a demonstration, and, if so, what sort of system should be demonstrated. The authors lay out major options available in designing both a demonstration and ultimately a national program. Where possible, they identify options that appear to be most attractive on analytic grounds, endeavoring in the process to give reasons for the selection. They also note the decisions that must be made by HCFA before a demonstration can be fielded. In these cases the authors try to outline the advantages and disadvantages of each approach.

This study is basically a "thought piece." It lays out the pros and cons of various approaches and notes what is known and unknown. It also points out the need for a variety of nonexperimental analyses that should be completed before a demonstration is mounted. Many of these analyses are currently under way at Rand, and the results will be documented in a later report.

C. R. Neu was responsible for direction of the work reported here and for the preparation of this draft. Credit for the content and the writing of specific sections goes to the following individuals:

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## SUMMARY

The establishment of the Medicare prospective payment system (PPS) for hospitals has produced new incentives for hospitals to discharge Medicare patients as quickly as possible. These incentives encourage the use of posthospital care provided by skilled nursing facilities (SNFs) and home health agencies (HHAs). Anecdotal evidence suggests that Medicare patients are in fact being transferred to posthospital care "quicker and sicker." That raises three concerns:

- Will the use of SNF and HHA services—and Medicare outlays for these services—increase sharply, partially defeating the cost-containment objectives of the hospital PPS?
- Will the quality of care received by Medicare patients decline because hospitals will discharge patients "too soon" to posthospital care settings?
- Do regional variations in the availability of SNF and HHA services result in inequities in the current PPS, giving hospitals with easy access to posthospital services a cost advantage over hospitals not so favorably situated?

These concerns have led some to seek adjustments in present Medicare policies for reimbursing posthospital care. Interest in a new payment mechanism is heightened by the perception that current policies are not working well: Finding SNF beds for Medicare patients is a chronic problem. Perhaps a different approach to reimbursing posthospital care would improve access for Medicare patients to such care.

## CHARACTERISTICS OF AN EXTENDED PPS

One way to overcome these potential and actual problems would be to extend the current PPS to include posthospital care. In return for a somewhat higher prospective payment, hospitals would assume financial responsibility for the posthospital care required by their Medicare patients. Hospitals would become responsible for the management of an entire episode of patient care and would thus have a financial incentive to make sure that Medicare patients receive an efficient mix of hospital and posthospital services. This approach to reimbursing posthospital care would also reduce the administrative burden borne by both HCFA and posthospital providers and might remove some of the most frequently cited obstacles to access by Medicare patients to posthospital care.

The principal characteristics of a PPS extended in this way would be as follows:

- Hospitals would be the residual claimants, financially responsible for both inpatient and posthospital care required by Medicare patients.
- Payments to hospitals would not be contingent on the actual use of posthospital services.
- Payments to hospitals would continue to be based on diagnosis related groups (DRGs).
- In general, hospitals would be financially responsible for readmissions of patients for the same condition that prompted hospitalization in the first place or for conditions that arise as a result of the care provided.
- Hospitals would be free to negotiate, with posthospital providers, whatever financial arrangements would be acceptable to both parties.
- Except for established patient copayments, posthospital providers would be required to accept payments from hospitals on behalf of Medicare patients as payment in full for covered posthospital services.
- Hospitals would be free either to provide necessary posthospital care themselves or to pay independent posthospital providers for such services.
- Hospitals would be free to provide Medicare patients with posthospital services that are not covered under current Medicare policies. These additional services would be at the hospital's expense.
- Hospitals would not necessarily be responsible for *all* posthospital services provided by current Medicare policies. Some limits would be placed on hospital liabilities, particularly with respect to the currently unlimited HHA benefit. Medicare benefits would not be reduced by an extended PPS; covered services beyond the responsibility of the hospital would be reimbursed by Medicare as they are today.
- Home health care that does not follow a hospital stay would continue to be reimbursed as it is presently, without the involvement of any hospital.

HCFA must resolve two important issues pertaining to an extended PPS. The first is whether an extended PPS should include home health care as well as SNF care. For efficiency reasons, it should include both kinds of posthospital care. To exclude home health care



would open troublesome loopholes in the system and provide incentives for less-than-efficient care; but to include it may create some administrative and political difficulties. (Appendix A of this report argues that the administrative difficulties are not insuperable.)

The second issue is whether some portion of the prospective payments received by hospitals is to be earmarked for posthospital care. Once again, efficiency argues against such a policy, but political pressures to protect the financial interests of traditional posthospital providers may require that hospitals be made to spend a specified amount on posthospital care.

## **PAYMENT EPISODES IN AN EXTENDED PPS**

In the hospital PPS, the hospital is responsible for the nonphysician costs of treating a Medicare patient for as long as he or she is in the hospital. Similarly, in an extended PPS, the hospital would be responsible for the nonphysician costs of an entire episode of patient care. Unfortunately, it is not as easy to define an episode of patient care in an extended PPS as it is in the hospital PPS. We offer two definitions of an episode of care in an extended PPS, providing two alternative limitations on hospital responsibilities.

A “minimalist” definition makes a hospital responsible for 20 days of SNF care, 20 home health visits, or some combination of the two adding up to 20. The hospital is generally absolved of responsibility for care provided more than 50 days after discharge from the hospital. This approach minimizes the period during which a hospital must monitor a discharged patient’s care, and frees the hospital from responsibility for collecting patient copayments for SNF care. (These payments are required only after the 20th day of SNF care.) Because HCFA will still have to reimburse SNFs directly for some care, however, SNFs will still have to file Medicare cost reports, partially defeating the objective of reducing administrative burdens on HCFA and on providers.

A “maximalist” definition makes a hospital responsible for all 100 days of covered SNF care and for up to 60 days of HHA care. Hospital responsibility generally ends 190 days after discharge from the hospital. This approach requires hospitals to follow patients for longer; but it eliminates all need for HCFA to reimburse SNFs directly and therefore eliminates the need for SNF cost-reports.

➤ In both approaches, hospitals are responsible for posthospital care of all discharged Medicare patients; the current three-day qualifying stay for SNF care is eliminated. All posthospital care that is currently

provided by Medicare but that falls outside hospital responsibilities in an extended PPS will be reimbursed directly by HCFA on the same cost basis as it is today.

## **SETTING PAYMENT RATES FOR AN EXTENDED PPS**

The approach to setting reimbursement rates for an extended PPS would be essentially the same as was used in setting reimbursement rates for the current PPS. The average cost of an episode of care during some base year would be calculated for each DRG. These average costs would provide cost "weights"—relative costs of care for each DRG. These weights would be converted into actual payments by multiplying weights by a constant factor chosen so as to make total outlays for an extended PPS roughly equal to what outlays would have been under the present system. In an extended PPS, the episode of care includes both inpatient and posthospital care.

As a practical matter, what is required is the calculation of an additional payment—an "add-on" to current DRG payments—to cover the costs of posthospital care. This add-on may be calculated either directly by averaging costs for posthospital care in each DRG, or indirectly by averaging total episode costs in each DRG and then subtracting the current DRG payment to arrive at an add-on for posthospital care. These calculations may have to be performed using data from the period before PPS was implemented, a time when incentives for and actual use of posthospital care differed from what they are now or would be in an extended PPS. This will introduce some bias into the data, and neither of the two calculation methods will produce truly "correct" reimbursement rates for an extended PPS. The two methods will bound the "correct" values, however, and will provide some indication of the reliability of the reimbursement rates calculated.

As in the current PPS, "national" reimbursement rates calculated in this manner will have to be adjusted for differences in local wage costs and for urban/rural cost differences. Like hospital reimbursement rates (at least after the current transition period), these add-ons for posthospital care will presumably not be adjusted to reflect differences in practice patterns.

During a demonstration, however, adjustments might be made that would not be made in a nationwide implementation of an extended PPS. Because a demonstration is by definition a temporary state of affairs, we might not see the convergence in practice patterns that might follow the permanent establishment of the system. Thus, equity might be served—during a demonstration—by adjusting reimbursement

rates to reflect recent local experience in the use of posthospital care. Within a particular demonstration site, however, all hospitals would receive equal reimbursement. Unlike the hospital PPS, posthospital capital costs would not be passed through to HCFA. Hospital payments to posthospital providers would cover the latter's capital costs.

## **THE ADEQUACY OF DRGs AS A BASIS FOR AN EXTENDED PPS**

The current set of DRGs provides the only readily available basis for patient classification in an extended PPS. Of course, DRGs were not devised with posthospital costs in mind, and whether they provide an adequate basis for an extended PPS remains an open question and one that must be resolved before embarking on a demonstration.

It is not necessary that DRGs be good predictors of posthospital costs. It is enough that they be good predictors of total episode costs. Even so, two kinds of problems may arise in using them in an extended PPS. First, the inclusion of posthospital costs may increase the variability of costs within DRG to unacceptable levels. Second, hospitals may be able to identify patients who are more likely than others in the same DRG to require posthospital care and be tempted to discriminate against these patients in admissions policies. Some minor adjustments in current DRGs are probably possible to alleviate these problems. If minor adjustments are not sufficient, however, the entire idea of an extended PPS may have to be abandoned until a new means of patient classification is devised.

## **REGIONAL VARIATIONS IN ACCESS TO POSTHOSPITAL CARE**

There is some evidence that access by Medicare patients to posthospital care varies from area to area. This seems particularly true in the case of SNF care. If these regional differences in access cannot be reduced or eliminated by a new payment scheme for posthospital care, they may cause difficulties in a payment system premised on equal access. To the extent that these differences exist, they seem to arise more from an unwillingness on the part of some posthospital providers to treat Medicare patients than they do from shortages of posthospital services. Fortunately, an extended PPS might eliminate some of the most frequently cited disincentives for treating Medicare patients.

A principal complaint about current Medicare reimbursement policies is that Medicare fiscal intermediaries retrospectively and



unpredictably deny coverage for posthospital care. Often this denial comes after the patient has been discharged, making it difficult for providers to collect from patients. An extended PPS should alleviate this problem because decisions about what is appropriate care will be arrived at jointly by hospitals and posthospital providers, without any HCFA involvement. A hospital wishing to refer patients in the future will have an incentive to devise review procedures that are acceptable to posthospital providers.

Similarly, an extended PPS could eliminate the extensive cost-reporting now required of SNFs and often cited as a reason for SNF refusal to accept Medicare patients. If the "maximalist" definition of hospital responsibilities is adopted, SNFs will have no direct dealings with HCFA, and HCFA-mandated cost-reports can be dispensed with.

SNFs are unwilling to accept Medicare patients because these patients sometimes require more expensive care than do others, but current Medicare policies do not always provide for higher rates of reimbursement. In an extended PPS, hospitals would have a strong incentive to pay sufficiently well for the care of Medicare patients to be able to transfer them to SNFs. It will be in the interests of both hospitals and posthospital providers to work out payment arrangements that reflect the true costs of necessary posthospital care.

Even if a new payment scheme cannot eliminate regional differences in access to posthospital care, it might still be worthwhile. The essential inequity caused by unequal access is not a characteristic of an extended PPS; it is a feature of the current hospital PPS. Hospitals without ready access to posthospital care are at a disadvantage today. Extending the PPS—even in the absence of equal access to posthospital care—will reduce this disadvantage.

## ADMINISTRATIVE CONSIDERATIONS

In an extended PPS, Medicare will continue to reimburse providers retrospectively for bad debts in much the same way that it does so today. Medicare-mandated cost-reporting may be dispensed with for SNFs if a "maximalist" definition of hospital responsibility is chosen, but not if hospital responsibilities are more limited. HHAs will have to continue to file cost-reports since some of the care they provide will be directly reimbursed by HCFA. In an extended PPS, fiscal intermediaries will continue to review hospital admissions as they do today. They may no longer, however, have to review transfers to posthospital care; the hospital paying for this care will assume primary responsibility for assuring that such care is necessary and is covered by Medicare benefits. Peer review organizations will continue their roles of

reviewing hospital admissions, certifying DRGs, and monitoring the quality of care. In an extended PPS, they may have to take on the additional function of arbitrating disputes between hospitals and posthospital providers about appropriate levels of care for particular patients.

## DEMONSTRATION DESIGN FOR AN EXTENDED PPS

A demonstration of an extended PPS would be intended to test the administrative feasibility of such a payment scheme, its impact on Medicare costs and on the health services marketplace, its effects on access to posthospital care, its fairness to hospitals and posthospital providers, and its implications for the quality of care provided to Medicare patients. To these ends, the payment scheme should be as much like the one proposed for national implementation as possible. A demonstration should also provide information on the relative attractiveness of alternative formulations of the payment mechanism, and should therefore include alternative "treatments"—or versions of the proposed payment system. Of particular concern are the effects of different levels of hospital responsibility for posthospital costs, and some demonstration sites should feature "maximalist" hospital responsibilities and some "minimalist" responsibilities.

Hospitals and posthospital providers participating in a demonstration of an extended PPS would agree to accept payment under the terms of the new system. In addition, they would agree to supply information necessary for the full evaluation of the demonstration. They would receive some compensation beyond the payments made on behalf of Medicare patients to cover the extra administrative costs associated with participation in the experiment.

Demonstration sites should encompass entire health services market areas; and within each demonstration site, participation should be universal among the hospitals that are now subject to the hospital PPS. Partial participation would leave demonstration results open to challenge on the grounds that the hospitals that participated were not representative of all hospitals. It might also provide incentives for utilization and referral patterns that would not be present in a universal implementation of the system and might thereby invalidate the results of the demonstration. To achieve universal participation within a demonstration site, it will probably be necessary to make participation mandatory for hospitals. Participation by posthospital providers will also be mandatory in the sense that if they are to treat Medicare patients referred by participating hospitals, they will have to accept the



terms of the new payment system. Mandatory participation will force all providers to accept the terms of the extended PPS if they wish to treat Medicare patients. It will not force any institution to treat Medicare patients. In a nationwide implementation of an extended PPS, providers could choose not to care for Medicare patients, and it would be valuable to observe this undesirable outcome in a limited demonstration rather than belatedly, after the new payment scheme had been implemented nationwide.

Demonstration sites would be chosen so as to test the proposed payment system in a variety of circumstances. Sites would be spread over several states to test the effects on the availability of posthospital care, of differing state Medicaid programs, and of differences in state policies toward the licensing of nursing homes and home health agencies. Sites would be chosen in urban and rural areas and in areas with widely differing historical utilization rates for posthospital services. A minimum of six demonstration sites in four states would be required for an adequate demonstration of one version of the proposed system. If a second version is to be tested (most likely using a different definition of hospital responsibilities), two or three more sites would be required. "Control" information would be gathered in each site before the beginning of the demonstration and in control sites during the demonstration.

The need to find control sites that are similar to the demonstration sites in important respects argues against using an entire state as a demonstration site. Because state programs and policies are thought to play important roles in determining the availability of posthospital services, it is important to have both demonstration and control sites subject to the same state regulations. If an entire state were used as a demonstration site, no control site subject to the same regulations would be available.

The treatment period of the demonstration is the time during which hospital discharges are reimbursed under the terms of the extended PPS. This period should last a minimum of two years for each site. In some sites it may be desirable to extend this treatment period if it appears that adjustment to the new payment scheme will not be fully observed in two years. It may also be useful to promise reimbursement under the new set of rules for a longer period—say, five years—in order to encourage providers to make longer-term investments in response to the new payment arrangement. It would not be necessary to observe behavior in a site for the full five years to gather useful information. If longer-term investments are being made they should be visible during the first two years. Observation of the results of a two-year treatment period, the provision of some time for collection of control data before

the demonstration is begun, and the difficulty of starting all demonstration sites at the same time, add a year to a year and a half to the duration of the demonstration. A satisfactory demonstration of an extended PPS will require a minimum of four years and perhaps longer from detailed planning to final solution.



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## I. INTRODUCTION

Now that a system for prospective reimbursement of Medicare hospital services has been implemented, attention has turned to the possibility of somehow extending the principle of prospective payment to providers of posthospital care: skilled nursing facilities (SNFs) and home health agencies (HHAs).

Current interest in extending the prospective payment system (PPS) is partly the result of legislative mandate. The legislation that called on the Department of Health and Human Services (DHHS) to devise a method of prospective payment for hospital care<sup>1</sup> also required DHHS to offer proposals for applying such a system to SNF care and, if feasible, to care in other settings. More recently, the Deficit Reduction Act of 1984<sup>2</sup> called on DHHS to report to Congress on possible approaches to prospective payment for SNF services and on available options for incorporating SNFs into the hospital PPS. More fundamentally, interest in some form of prospective payment for posthospital care has the same roots as the earlier interest in prospective payment for inpatient services: concern over the rate of increase of Medicare outlays and a desire to encourage more efficient and (it is hoped) less costly provision of health care.

But there is probably little to be gained simply by encouraging more efficient provision of posthospital care. The use of posthospital services (and especially the use of home health services) by Medicare beneficiaries has been growing, but these services still account for only a small share of total Medicare outlays. During the first half of 1984, for example, SNF care accounted for only 1.1 percent of all Medicare Part A outlays, and home health services accounted for only another 4.3 percent.<sup>3</sup> Even dramatic efficiency gains by these providers would have only a marginal impact on total Medicare costs. If any major budgetary gains are to be made, they will come from more efficient use of the entire complex of hospital and posthospital services.

One possible mechanism for encouraging efficient use of various health care services is the integration of posthospital services into the existing PPS for hospital services. Hospitals would be made financially responsible for an entire episode of patient care, posthospital as

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<sup>1</sup>The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Public Law 97-248.

<sup>2</sup>Public Law 98-369.

<sup>3</sup>"Health Care Financing Trends," *Health Care Financing Review*, Vol. 6, No. 3, Spring 1985, pp. 89-98.

well as inpatient care. The hope is that centralizing financial responsibility would create new incentives for utilizing an efficient mix of hospital and posthospital care.

Whether such an extension of the current PPS is in fact feasible, whether it would yield significant efficiencies and cost savings, and whether it would be consistent with maintaining current standards of medical care for the elderly are unknown. There is no relevant experience with such systems on which to base judgments. Ultimately, these questions can be resolved only by experimenting with an extended PPS and observing the consequences. Rather than perform this experiment in the form of a nationwide implementation of an extended PPS, it would seem prudent first to mount a small-scale demonstration project.

The first step toward designing a demonstration, of course, is to characterize the system to be demonstrated. Resources should not be wasted demonstrating options that are unlikely to support the policy objectives of reducing costs, maintaining quality of care, improving access for Medicare beneficiaries to necessary care, and guaranteeing generally equitable treatment of health care providers. We therefore devote considerable attention in this report to the likely implications of particular features of an extended PPS. We note what questions about an extended PPS can be addressed through analysis of existing data, and what questions can be answered only through a demonstration. If there is doubt about the best form of an extended PPS, a demonstration should provide the information necessary to resolve this doubt. Similarly, there is no point in demonstrating options that are not feasible politically. The resolution of political issues is not within our province, but we will point them out wherever they seem relevant. No matter what options are demonstrated, we will learn nothing if the demonstration does not allow a full evaluation of the proposed system. A detailed evaluation plan is beyond the scope of this report. Our intent is to lay out clearly the major questions to be resolved, and to show how a demonstration can be structured to provide the necessary information.

Such a demonstration will be a major undertaking. It will require the participation of scores of hospitals and posthospital providers and will affect the care of thousands of Medicare patients. Its design, operation, and evaluation will require a minimum of four years and possibly longer. Deciding whether the effort is worthwhile is ultimately up to the Health Care Financing Administration (HCFA). In this report, we will lay out what might be learned from a demonstration, what the alternatives to a demonstration are, and the risks inherent in these alternatives.



In the pages to follow, we first characterize an extended PPS and then develop a demonstration for testing it. The report comprises three major parts. The first discusses the nature of an extended PPS. Section II lays out the motivation for and the objectives of such an extension, and Section III derives the basic characteristics of a system that meets these objectives. Sections IV and V deal with two central issues in making an extended PPS operational: how to define an episode of care and how to set reimbursement rates. Sections VI and VII treat two potentially serious obstacles to an extended PPS: the possible inadequacy of the present system of diagnosis related groups (DRGs) as a basis for an extended PPS and regional variations in access to posthospital care. Section VIII concludes Part I with a discussion of some important operational considerations.

The second part is devoted to the design of a demonstration. Section IX lays out the objectives. Section X discusses what will be required of institutions that participate in the demonstration and how such participation is to be ensured and compensated. Section XI offers some views on how demonstration sites may be selected.

The third part, consisting of three appendixes, provides discussions of three aspects of an extended PPS and its demonstration: the inclusion of home health care in an extended PPS (App. A), the treatment of outliers (App. B), and whether to permit "swing" beds in an extended PPS (App. C).



## II. MOTIVATION

The establishment of a prospective payment system (PPS) for hospitals has changed the incentives that hospitals face—in particular, when deciding whether to keep a Medicare patient in the hospital or to discharge him or her to some form of posthospital care. (More accurately, PPS has changed hospitals' incentives in trying to influence physicians, for they are the ones who decide on appropriate treatment for patients.) Under the previous cost-based system of hospital reimbursement, the hospital generally had an incentive to keep the patient in the hospital. Medicare reimbursed the hospital for most of the operating costs it incurred in treating a patient for several more days; and unless the bed vacated by the departing Medicare patient were immediately filled by a new patient, the hospital lost money it needed to cover its overhead costs. PPS, in contrast, gives a hospital an incentive to discharge Medicare patients as early as possible. Medicare now pays a fixed amount for the inpatient care of a patient. The hospital can keep any cost savings it achieves in treating the patient (perhaps by prompt discharge). The sooner one Medicare patient is discharged, the sooner the hospital can admit another, thereby earning another fixed payment.

These new incentives encourage hospitals to make greater use of posthospital care provided by skilled nursing facilities (SNFs) and by home health agencies (HHAs). If Medicare patients who otherwise would have remained in the hospital can be transferred to posthospital care, hospitals can reduce their costs with no loss in revenues. As yet there is no firm statistical evidence that the use of posthospital care has increased since the institution of PPS, but there is considerable anecdotal evidence that hospitals are transferring patients "quicker and sicker" to posthospital care.

Some increased use of posthospital care is probably desirable. Under the earlier reimbursement system, some Medicare patients who could have been transferred to posthospital care settings remained in more expensive hospital settings. The fear now is that the new incentives may result in excessive or inappropriate use of posthospital services. If they do, the cost-containment apparatus put in place with the hospital PPS may begin to "leak" as reduced hospital costs reappear in the form of higher outlays for SNF or HHA care. The new incentives could also result in a decline in the quality of care received by Medicare patients if hospitals are encouraged to discharge patients "too soon" to posthospital care settings.

Another concern arises over the well-known regional differences in the availability of posthospital services (particularly SNF services). Little is known about the causes of this variation. To the extent that it is due to factors beyond the control of hospitals, inequity may result. Hospitals with easy access to posthospital care will be able to discharge Medicare patients sooner, and therefore (under the current PPS) enjoy a cost advantage over hospitals not so favorably situated. These concerns have led some to seek adjustments in present Medicare policies for reimbursing posthospital care.

A further spur to such thinking comes from the observation that current policies for reimbursing posthospital care are apparently not working very well. Finding SNF beds for Medicare patients is a chronic problem. A 1980 survey conducted by the American Association of Professional Standards Review Organizations, for example, found Medicare paying for some six million days of hospital care each year for patients who were simply waiting for SNF beds.<sup>1</sup> Some of this backlog is undoubtedly due to local shortages of SNF beds, but anecdotal evidence has it that a more serious bar is the reluctance of many SNFs to accept Medicare patients.

This anecdotal evidence is plausible in light of the small share of the nursing home market accounted for by Medicare patients. Medicare patients account for only about 2 percent of total nursing home revenues<sup>2</sup> and occupy only about 7 percent of the beds in nursing homes certified to care for Medicare or Medicaid patients.<sup>3</sup> It is therefore unlikely that the Medicare patient load is straining the capacity of existing posthospital care institutions. More likely, the levels of Medicare reimbursement, the burdens of Medicare-mandated cost-reporting, and the sometimes unpredictable application of Medicare eligibility criteria, discourage the treatment of Medicare patients. Perhaps some other method of reimbursing posthospital care would improve matters.

One way to overcome these potential and actual problems would be to extend the current PPS to include posthospital care. Doing so would make the hospital financially responsible for both inpatient and posthospital care required by Medicare patients. The hospital would

<sup>1</sup>U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearings*, February 2, 1982. Testimony of Samuel Gunnerson, Gunnerson Associates, Indianapolis, Indiana, p. 38.

<sup>2</sup>*Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, Health Care Financing Administration, U.S. Department of Health and Human Services, January 1985, p. 22.

<sup>3</sup>Judith Feder and William Scanlon, "The Underused Benefit: Medicare's Coverage of Nursing Home Care," *Milbank Memorial Fund Quarterly*, Vol. 60, No. 4, 1982, pp. 604-632.

receive a prospectively determined payment for the care of each Medicare patient. This payment would presumably be somewhat higher than the payment a hospital currently receives today for inpatient care only. In return for the extra payment, the hospital would be required to arrange and to pay for whatever covered posthospital services are required by its Medicare patients.

A PPS extended in this way would eliminate a hospital's incentive simply to discharge a patient as quickly as possible. Instead, it would give the hospital an incentive to provide that mix of inpatient and posthospital services that allowed for the most efficient treatment of an entire patient episode. It would also allow for some reductions in the burden of administering the Medicare program; decisions now made by HCFA or by fiscal intermediaries about the appropriateness of posthospital care in particular cases might be left to hospitals in an extended PPS. Finally, changing the basic mechanism by which providers of posthospital care are reimbursed offers an opportunity to make Medicare patients more attractive to these providers and thus improve access to posthospital care for Medicare patients.

### III. CHARACTERISTICS OF AN EXTENDED PPS

In this section we discuss the basic characteristics of an extended PPS. We also note two issues concerning the character of such a system that HCFA policymakers will have to resolve.

#### BASIC CHARACTERISTICS

*Hospitals would be residual claimants in an extended PPS, financially responsible for both inpatient and posthospital care.* The establishment of separate systems of prospective payment for SNF and HHA care would probably accomplish little. Prospective payment of SNFs and HHAs would perhaps encourage more efficient operation by providers of posthospital care; but these providers account for only a small share of total Medicare outlays, and even very striking efficiency gains would produce only modest savings for the entire Medicare program. Significant gains are more likely to arise from the efficient use of the whole set of hospital, SNF, and HHA resources. The aim of a reworked reimbursement system, therefore, should be not only the efficient provision of care by any particular institution but also an efficient mix of services from a variety of providers. In particular, the reimbursement system should provide an incentive for efficient choices at the boundary between hospital and posthospital care. A separate system of prospective payment for posthospital care would not address this issue.

Efficient management of the entire episode of care will require that one agent have both the power to manage, and the financial responsibility for, an entire treatment episode. The hospital to which a patient is first admitted is the logical choice for this role. The hospital would receive a prospectively determined payment for the care of a Medicare patient. It would then arrange and pay for whatever services—inpatient, SNF, or home health—this patient required. This necessarily involves the hospital in the management of the entire episode and gives it a financial stake in the efficient use of hospital, SNF, and home health resources.

Hospitals do not, of course, have full control over patient management. Decisions to admit, to discharge, and to transfer patients are made by physicians. Hospitals do, however, influence these decisions, and there is presumably some benefit in making sure that this influence is exerted in the direction of efficient provision of care.



*Payments to hospitals would not be contingent on the actual use of posthospital services.* The aim of an extended PPS is to induce hospitals to provide Medicare patients with an efficient mix of inpatient and posthospital services. This aim would not be well served if payment to a hospital for the care of a particular patient were contingent on that patient's use of posthospital care. An extra payment to cover the costs of posthospital care for only those patients who actually used such care would give hospitals an artificial incentive to transfer patients to posthospital care—particularly if, as is often the case, the hospital itself operates an SNF or an HHA. The result could be excessive use of posthospital care—transfers to posthospital care of patients who only marginally need it. The aim of encouraging an efficient mix would be better served by paying hospitals a small additional amount for *every* Medicare patient treated, and then allowing the hospital to determine which patients required posthospital care.

The amount of this extra payment would reflect the fact that most Medicare patients do not require posthospital care. It would therefore be considerably smaller than the actual cost of posthospital care for any one patient.

*Payments to hospitals would continue to be based on DRGs.* As noted above, posthospital costs constitute only a small fraction of total Medicare outlays. Consequently, to change the entire basis for making prospective payments to hospitals simply to incorporate posthospital care into the prospective payment system would be to let a rather small tail wag a rather large dog. The only practical approach is to use the current set of DRGs (or a slightly adjusted version of the current set) as a basis for prospective payment in an extended PPS. The extra amounts paid to hospitals to cover expected posthospital costs would depend, as payments for inpatient care do today, on the patient's DRG. Those amounts would reflect both the likelihood that a patient in a particular DRG will need posthospital care, and the expected cost of that care if it is needed. Whether or not the current set of DRGs is adequate for this purpose is a subject for further research. A more thorough discussion of this issue can be found in Sec. VI.

*In general, hospitals would be financially responsible for readmissions for the same condition.* If there is to be no incentive for "too early" transfers from hospitals to posthospital care settings, hospitals must be financially responsible for the consequences of a transfer. This means that, as a general rule, hospitals will have to readmit any patient needing further hospital care without receiving additional reimbursement. Of course, if the patient develops some new condition during posthospital care—some condition that is not related either to the condition that originally brought him to the hospital or to the care he received while



in the hospital—the hospital would be entitled to treat the readmission as a new episode and be reimbursed accordingly.

While this general rule is quite clear, its practical application may pose some difficulties. Some review of readmissions would be required to determine if there were some exogenous cause for readmission. This difficulty already exists with the present PPS system for hospitals, and peer review organizations (PROs) already review hospital admissions to certify the necessity of the admission and the classification into a particular DRG. They also verify that readmissions are indeed for treatment of a new condition, and are not simply double-payment dodges. PROs could do the same thing in an extended PPS.

It is conceivable that, for some DRGs, no clear definition of an episode would be possible. That would be true in the familiar case of “cycling”—wherein patients move back and forth again and again between the hospital and SNF. This problem, too, already occurs within the hospital PPS, and bundling hospital and posthospital care together may further complicate matters. A demonstration would help to determine how serious the problem is.

*Hospitals would be free to negotiate financial arrangements with posthospital providers.* Hospitals and posthospital providers would be free to negotiate whatever arrangements for payment and access might be agreeable to both parties. Hospitals would have an incentive to pay enough to find access for their patients, and posthospital providers would seek to attract the referrals that hospitals can offer. Since these arrangements would be mutually agreeable, there should be little reason for posthospital providers to refuse to accept Medicare patients. The nature of these arrangements will not change the costs of care to HCFA; HCFA will pay the hospital a fixed amount for each patient. How the hospital buys posthospital care would be a matter of fiscal indifference to HCFA.

While free negotiations between hospitals and posthospital providers are attractive, there are possible drawbacks. All parties would have to bear the administrative burdens and uncertainties associated with what could be rather complex negotiations. In the face of these costs, both sides might tend to restrict the number of negotiations undertaken and thus to limit the number of final agreements in force. Patients might then find their choice of posthospital provider limited to those (perhaps few) institutions that the hospital in question had gotten around to negotiating agreements with.

Such problems are likely to be temporary, marking only the early months of operation of an extended PPS. As hospitals and posthospital providers become more accustomed to the demands of local competition and more adept at negotiating, the obstacles to reaching agreements should be reduced. In a demonstration of limited duration,

however, these start-up problems could be significant; Sec. X discusses some ways to get around them.

*Except for established copayments, posthospital providers would be required to consider payments received from hospitals on behalf of Medicare patients as payment in full for covered services.* The hospital PPS permits hospitals no financial recourse to patients beyond established deductibles and copayments. There seems no reason to deviate from this policy in an extended PPS. Patient copayments for more than twenty days of SNF care would continue under an extended PPS. It would generally be the hospital's obligation to try to collect these amounts, although the hospital could arrange for the SNF to collect them on its behalf. As in the hospital PPS, hospitals could be reimbursed retrospectively by HCFA for bad debts that remain after reasonable attempts at collection.

*Hospitals would be free to "make" or to "buy" posthospital care.* If a hospital believes that it can provide posthospital care for its patients (perhaps, for example, by establishing its own nursing facility or by converting some of its beds to "swing" beds) more efficiently than it can purchase such care from outside agencies, it should be free to do so. Who provides posthospital care will be a matter of fiscal indifference to HCFA, since the costs of the entire episode are fixed.

*Hospitals would be free to provide posthospital services that are not covered under present Medicare policies.* The intent of an extended PPS is to leave the Medicare posthospital care benefit unchanged. Hospitals would be financially responsible for providing at least all presently covered posthospital services. If, however, a hospital believed that a particular patient could be more efficiently cared for by means of posthospital services that are not presently covered (for example, by providing the patient with daily home health visits—generally not permitted by current policies) it would be free to do so at its own expense. Such "extra" care would cost HCFA nothing.

*Some limit would be placed on hospitals' financial and administrative responsibilities.* The Medicare home health benefit is open-ended; patients are eligible for an unlimited number of home health visits. It would be impractical to require that hospitals monitor and pay for care received by patients over an indefinite period of time. Some limit—defined in terms of the amount of care that a patient has received or simply in terms of calendar days elapsed since a patient's discharge—would be set on the hospital's responsibility. Covered services beyond this limit would be paid for by HCFA on the same basis as covered posthospital services are reimbursed today. Limits on hospital responsibility would be chosen so as to leave hospitals responsible for as large a share of covered posthospital costs as seems practically possible. (For more on how these limits might be set, see Sec. IV.)

*Only posthospital services would be covered by the extended PPS.* Current Medicare regulations allow home health-care visits without a prior hospitalization. The extended PPS would not eliminate these visits, but of course there would be no way to make a hospital financially responsible for them. Thus, home health care that does not follow from a hospitalization would continue to be reimbursed as under present Medicare arrangements.

## ISSUES TO BE RESOLVED

*Should an extended PPS include home health care as well as SNF care?* As we have seen, the present application of prospective payment only to hospitals encourages "too early" transfers to posthospital care. A combined PPS for hospital and posthospital care is aimed at eliminating this incentive.

An extended PPS that included only SNFs would do nothing to discourage "too early" transfers to home health care. Further, an extended PPS limited to SNFs would establish a strong disincentive for hospitals to transfer patients to SNFs: If a patient goes to a SNF, the hospital must pay for his or her care; if the patient is transferred to home care, the hospital pays nothing. The result is likely to be overuse of home health care and underuse of SNF care. Finally, an extension of the current PPS only to SNFs would miss the bulk of Medicare outlays for posthospital care. Medicare outlays for home health care are nearly four times the outlays for SNF care. One wonders if an extended PPS covering only SNF care (which accounts for only a bit more than 1 percent of all Medicare Part A outlays) is worth the trouble of setting up. Clearly, an ideal implementation of an extended PPS would include home health agencies.

Objections to the inclusion of home health agencies in an extended PPS generally center on the additional complexity that might be introduced into the system by including home health care and on the fear of political opposition. (Significantly, none of the Congressional mandates to study extensions of the PPS has made explicit reference to home health care.) How serious these obstacles really are is not known. Indeed, the only way to find out if inclusion of home health care would unduly complicate the system would be to include it in a demonstration project and see what problems arise. (Appendix A considers this issue more closely and argues for inclusion.)

A related issue is whether an extended PPS should also include rehabilitation hospitals. Such hospitals have been exempted from the



current PPS and are still reimbursed on a cost basis. These hospitals have received little attention and almost no historical data are available on their patients and services. This is largely because, before PPS, there was no reason to distinguish rehabilitation hospitals from short-stay, acute-care hospitals. Some evidence suggests, however, that rehabilitation hospitals may constitute a form of posthospital care that is at least partially substitutable for SNF and home health care. More than 80 percent of rehabilitation hospital patients, for example, are admitted after a stay in a short-term hospital. To the extent that rehabilitation hospitals are a form of posthospital care, there is reason to consider including them in an extended PPS. Until more background information on them is available, however, no conclusive case can be made for including them in an extended PPS.

*Should some portion of prospective payments to hospitals be earmarked for posthospital care?* Under an expanded PPS, hospitals would be paid some extra amount beyond what they receive today for the care of each patient. This extra amount would be intended to cover posthospital care. The question is whether hospitals are to be required actually to spend this amount for posthospital care, or are to be free to use it as they see fit.

If the goal of the entire prospective payment exercise is to encourage efficient utilization of health care resources, then no constraints should be placed on the funds that the hospital receives. It is hoped that when patients can be more cheaply cared for in an SNF or home health setting, the hospital will have an incentive to arrange such care. There should be no restrictions on how funds paid to the hospital are to be spent.

The stumbling block here may be fears by the providers of posthospital care that prospective payment is simply a way of encouraging hospitals to do without posthospital services altogether, or of allowing hospitals to usurp the role of traditional posthospital providers. This outcome seems unlikely, but fear of it could hinder the implementation of an extended PPS and could completely block a demonstration. The stronger this fear, however, the more important it becomes to allow hospitals to make unconstrained use of the funds they receive during a demonstration. Only by allowing such freedom will it be possible to test whether an extended PPS is a threat to existing posthospital providers.



## IV. PAYMENT EPISODES IN AN EXTENDED PPS

The basic approach to reimbursement in an extended PPS will resemble that in the current hospital-only PPS: Hospitals will be paid a prospectively determined amount for the treatment of an entire episode of patient care. In the current hospital-only PPS, it is easy to define a hospital's financial responsibilities: Hospitals are responsible for the covered nonphysician costs of treating a patient during the hospital stay. In an extended PPS, however, such definition is not so simple. A hospital will presumably not be held responsible for *all* care subsequent to a hospitalization; but in an extended PPS there is no natural definition of what constitutes an episode of care.

In designing an extended PPS, we have opted for a purely operational definition of a treatment episode: An episode includes whatever services a hospital is responsible for. Thus, to define an episode is also to set limits on hospitals' responsibilities. The choice of a particular definition of what constitutes a treatment episode does *not* in any way reduce the benefits received by Medicare beneficiaries. Medicare benefits will be unchanged by the implementation of an extended PPS. Benefits that are not the responsibility of the hospital will continue to be reimbursed directly by HCFA on a cost basis.

In choosing a definition for a payment episode, we must be conscious both of what a particular definition may mean for the operation of the system and of whether a particular definition lends itself to the calculation of appropriate reimbursement rates. Below we offer two definitions (which we term "minimalist" and "maximalist") of an episode of care. Both seem feasible and would allow the setting of reimbursement rates through the use of available data. They may have quite different implications for the operation of an extended PPS, however. These implications can be tested fully only through a demonstration, in which it would probably be wise to include both definitions.

### CURRENT MEDICARE BENEFITS

Current Medicare benefits offer some guides in defining the extent of hospital responsibility in an extended PPS. Current Medicare policy provides for up to 100 days of SNF care during a so-called "benefit

period.”<sup>1</sup> For the first 20 days, Medicare pays fully for covered services; after the 20th day, the patient is responsible for substantial copayments. These limits—20 days of fully reimbursed care and 100 total days of care—provide some natural endpoints for hospital responsibility in an extended PPS.

To be eligible for SNF care today, a patient must enter an SNF within 30 days of discharge from a hospital, unless his or her “condition makes it medically inappropriate to begin an active course of treatment in an SNF immediately after hospital discharge, and it is medically predictable at the time of hospital discharge that he or she will require covered care within a predeterminable time period.”<sup>2</sup> It seems unreasonable in an extended PPS to require a hospital to follow a patient for lengthy periods while the patient is receiving no care, and still expect the hospital to be responsible for the care of that patient. The current requirement that SNF care commence within 30 days would therefore seem appropriate in an extended PPS. Today, a patient may be readmitted to the same or a different SNF within 30 days of discharge and maintain eligibility for Medicare coverage. In an extended PPS, similar interruptions in service would be permitted without absolving the hospital of financial responsibility for this care.

Not all provisions of current policy should be transferred to an extended PPS, however. To be eligible for the Medicare SNF benefit today, for example, a Medicare patient must have a qualifying hospital stay of at least three days. It should be possible, however, in an extended PPS to eliminate that requirement. By admitting a Medicare patient, the hospital assumes financial responsibility for his or her care, and the hospital should not be permitted to avoid responsibility for posthospital care simply by transferring the patient to such care after only two days in the hospital. The Tax Equity and Financial Responsibility Act of 1982 (P.L. 97-248) authorized the elimination of the three-day qualifying stay for SNF eligibility if this were found not to raise expenditures, but this legislation was never implemented in Medicare regulations.

Current Medicare policy is a less useful guide in defining a treatment episode for an extended PPS. Since July 1, 1981, no qualifying hospital stay is required for Medicare reimbursement of home health care. Neither is there any limit on the number of home health visits paid for by Medicare. In an extended PPS, hospitals would, of course,

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<sup>1</sup>A benefit period is a concept that determines a patient's eligibility for Medicare benefits. A benefit period begins when a patient is admitted to a hospital and has not been in a hospital or SNF for the previous 60 days.

<sup>2</sup>Skilled Nursing Care Facility Regulations.

be responsible only for home health care that followed a hospital stay. But some reasonable limits must be placed on the duration of hospital responsibility for home health care. No patient copayment is now required for home health care (except for durable medical equipment provided by a home health agency). In an extended PPS, a hospital would be responsible for the full costs of covered home health services deemed to be the hospital's responsibility.

## A GENERAL DEFINITION OF A TREATMENT EPISODE

The preceding considerations suggest three general principles for defining a treatment episode in an extended PPS. These principles are not intended to provide an airtight set of rules, but they should suffice for a demonstration, where simplicity is a major advantage. If a demonstration reveals serious loopholes in the rules derived from these principles, adjustments can be made before national implementation of the system.

**Principle 1.** An episode begins on the day a patient who is eligible for Medicare Part A benefits is admitted to a hospital. The episode ends upon any subsequent admission for a new condition (in other words, when the hospital receives a new prospective payment) or when a specified number of days elapse after discharge, whichever is earlier. No minimum hospital stay would be required prior to posthospital care.

There are two possible strategies for implementing this general principle. A "minimalist" strategy would make hospitals responsible for posthospital care for a relatively short period of time. A "maximalist" strategy would make hospitals responsible for as large a share of current posthospital care benefits as practical. Possible ways to implement both strategies are given below.

A **minimalist strategy** would try to include a sizable share of posthospital costs within a PPS, yet limit the length of time that a hospital would have to keep track of its discharged patients. A hospital would be held responsible for a total of 20 SNF days or 20 HHA visits or any combination of the two that add up to 20.<sup>3</sup> The 20-day figure provides a logical cutoff point for a minimalist strategy because an SNF patient is required to make sizable copayments after the first 20 days. Because an extended PPS is intended to encourage hospitals to provide posthospital treatment in the most efficient medically

<sup>3</sup>As the name implies, this approach is minimalist. The 20-day cutoff is shorter than the average SNF stay (29 covered days) and provides fewer days than the average home health treatment (25.5 visits per user per year).



appropriate setting, HHA visits and SNF days would be interchangeable.

An overall time limit would be placed on the hospital's responsibility for providing posthospital services. A total of 50 days from hospital discharge seems a logical limit. Under current regulations, a patient must generally enter an SNF within 30 days of hospital discharge. The hospital would then be responsible for up to 20 days of SNF care.

Finally, a 30-day interval outside an SNF under the current system ends a patient's eligibility for SNF benefits. Therefore, under a minimalist approach, it would be logical to end a hospital's financial responsibility for all posthospital care when the patient has remained outside an SNF for 30 days. Any Medicare-eligible posthospital care that is not the responsibility of the hospital would remain the responsibility of HCFA. Such care would be reimbursed, as it is now, on a cost basis by HCFA. Thus, a patient's benefits would not be affected by the extended PPS.

The attraction of this approach lies in the fact that hospitals would have to follow patients for only a short time after discharge. Hospitals would also be spared any responsibility for trying to collect patient copayments for SNF care. While hospitals would not be liable for all of the posthospital care that is now covered by Medicare, their liability would probably be great enough to encourage efficient use of posthospital care. The disadvantage in this approach lies in the need for HCFA to continue to pay directly for a significant share of all posthospital care, thus partially defeating one goal of an extended PPS system: reducing the administrative burden inherent in direct HCFA payment for posthospital care.

A **maximalist strategy** includes as much posthospital care as possible under an extended PPS. A hospital would be held financially responsible for all 100 days of SNF care now covered by Medicare. Patients would be required to make copayments after the 20th day, as in the current system. The discharging hospital would also be responsible for HHA visits within 60 days after the last discharge from an SNF or 60 days after SNF benefits have expired. Thus, a hospital would also be responsible for all HHA visits during the currently defined benefit period.<sup>4</sup> A logical time limit for services would be 190 days after discharge: A patient might wait 30 days after discharge before entering an SNF, he might remain in the SNF for 100 days, and there might be 60 additional calendar days of HHA responsibility after the 100 SNF days.

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<sup>4</sup>Unless the patient is readmitted to a hospital during the same benefit period.



The advantage in this approach is that HCFA would be completely free of any burden for directly reimbursing SNFs. With this strategy, all SNF care would be the responsibility of the hospital. As a result, SNFs would no longer have to maintain the cost-reporting apparatus required for Medicare reimbursement or deal with Medicare fiscal intermediaries. This would be a significant benefit to many SNFs and would perhaps provide an incentive for more SNFs to accept Medicare patients. HCFA would still have to reimburse some home health care, and HHAs would presumably have to continue filing cost-reports. But no definition of hospital responsibility could eliminate this requirement, since some covered home health care arises without any prior hospitalization. The drawback of this approach is that hospitals would be required to follow patients and monitor their care for extended periods.

**Principle 2.** The discharging hospital is financially responsible only for Medicare-eligible posthospital care related to the condition for which the patient was hospitalized.

Fairness suggests that hospitals should be responsible only for posthospital care directly related to the prior hospitalization. This is attractive as a practical matter also, since any other approach might encourage hospitals to discriminate against patients admitted from, say, a nursing home. Such patients would be likely to go back to a nursing home on discharge from the hospital, perhaps for treatment completely unrelated to the condition that required hospitalization. When the cause of posthospital care is in question, PROs will have to decide whether or not such care is related to the hospitalization.

While this principle is attractive in designing an extended PPS, it leads to difficulties in estimating appropriate payment rates for the extended system. It is impossible to determine which posthospital services paid for by Medicare in the past were in fact associated with a preceding hospital stay. The only practical course is to assume (incorrectly in some cases) that all such costs are associated with the most recent previous hospitalization.

**Principle 3.** A hospital receives a prospective payment for both hospital and posthospital care unless the patient is transferred to another hospital. A transferring hospital receives no payment for posthospital care, and a prorated share of the reimbursement for inpatient care, based on the ratio of the number of days it treated the patient to the average length of stay for the relevant DRG.

This principle reflects current Medicare policy regarding transfers, and addresses two potential problems in an extended PPS. First, there is no reason why a hospital transferring a patient should receive a

payment for providing posthospital care when it will never have to pay for such care. Second, if transfers are included in the overall episode counts, then the observed average cost of posthospital care per case would be too low, and payments to hospitals would not cover the costs of posthospital care they would be required to provide.<sup>5</sup>

Using these three principles, we can formulate more formally two candidate definitions of a treatment episode for an extended prospective payment system.

## REGULATIONS FOR A MINIMALIST APPROACH

### Hospital's Financial Responsibility

A hospital discharging a Medicare patient is financially responsible for all of his currently covered posthospital care with the following limitations:

**Unrelated Condition Limitation.** The hospital is not financially responsible for providing posthospital care unless such care is being provided for a condition for which the patient was hospitalized, or for a condition that arose in the course of his hospital care or subsequent related posthospital care.

**Day Limitation.** The hospital is not financially responsible for providing more than 20 days of posthospital care. Each day that a patient remains in an SNF, including the admission date but not the discharge date, counts as one day in calculating this limit. Any day on which a patient receives a visit from an HHA counts as one day. Multiple home health visits on the same day do not count as multiple days in determining the day limit.

**Time Limitation.** A hospital is not financially responsible for providing posthospital care more than 50 days after discharge.

**Interval Limitation.** The hospital's financial responsibility for providing posthospital care generally lapses if the patient does not begin such care within 30 days of discharge from a hospital. The hospital's financial responsibility for such care does not lapse after 30 days if the patient's condition makes it inappropriate to begin posthos-

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<sup>5</sup>Transfers cannot be easily identified in post data. Thus, calculations of reimbursement rates in an extended PPS would not reflect adjustments for transfers. This same problem affected the original calculations of reimbursement rates for the hospital PPS. No new problems arise in the case of the extended PPS.

pital care immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he will require covered care within a predeterminable time period. The hospital's responsibility also lapses if a patient has been out of a hospital for 30 days and out of an SNF for 30 days.

**Readmission Limitation.** The hospital's financial responsibility for providing posthospital care ends when the patient is admitted to the same or a different hospital for a new condition. An admission for a new condition means any admission for which a hospital receives a new prospective payment or would have received a new prospective payment if the patient had not exhausted his benefits. An admission to a hospital that is exempted from the prospective payment system for a condition that would have triggered a prospective payment in a nonexempt hospital also terminates the original hospital's financial responsibility for posthospital care.

## **Swing Beds**

When skilled nursing care is provided in a swing bed<sup>6</sup> of a hospital rather than in an SNF, the patient will be considered to have been transferred to an SNF.

The day on which a patient is transferred from a regular hospital bed to a swing bed shall be considered his day of discharge from the hospital.

## **Qualifying Stay**

Hospitals will be financially responsible for covered posthospital care required by all discharged Medicare patients, no matter how short their hospital stays have been. The three-day qualifying stay for SNF care is abolished.

## **HCFA's Financial Responsibility**

All Medicare-eligible posthospital care that is not the financial responsibility of any hospital will continue to be reimbursed directly by HCFA on the same basis as it is today.

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<sup>6</sup>Swing beds are hospital beds used for either acute or skilled nursing care. For a discussion of the role of swing beds in an extended PPS, see App. C.



## REGULATIONS FOR A MAXIMALIST APPROACH

### Hospital's Financial Responsibility

A participating hospital discharging a Medicare patient is financially responsible for all of his currently covered posthospital care with the following limitations:

**Unrelated Condition Limitation.** The hospital is not financially responsible for providing posthospital care unless such care is being provided for a condition for which the patient was hospitalized, or for a condition that arose in the course of his hospital care or subsequent related posthospital care.

**Day Limitation.** The discharging hospital is financially responsible for providing up to 100 days of SNF care. Subject to the other limitations in this section, the hospital is responsible for all the patient's home health visits.

**Time Limitation.** A hospital is not financially responsible for providing posthospital care more than 190 days after discharge from the hospital.

**Interval Limitation.** The hospital's financial responsibility for providing SNF care generally lapses if the patient does not begin such care within 30 days of discharge. The hospital's financial responsibility for SNF care does not lapse after 30 days if the patient's condition makes it inappropriate to begin posthospital care immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he will require covered care within a predeterminable time period. The hospital's responsibility for SNF care also lapses when the patient has been out of an SNF for 30 days. The hospital's financial responsibility for HHA care lapses when the patient has been out of a hospital for 60 days and has been out of an SNF for 60 days.

**Readmission Limitation.** The hospital's financial responsibility for providing posthospital care ends when the patient is admitted to the same or a different hospital for a new condition. An admission for a new condition means any admission for which a hospital receives a new prospective payment or would have received a new prospective payment if the patient had not exhausted his benefits. An admission to a hospital that is exempt from the prospective payment system for a condition that would have triggered a prospective payment in a nonexempt hospital also terminates the original hospital's financial responsibility for hospital care.



**Definitions**

When skilled nursing care is provided in a swing bed of a hospital rather than in an SNF, the patient will be considered to have been transferred to an SNF.

The day on which a patient is transferred from a regular hospital bed to a swing bed shall be considered his day of discharge from the hospital.

**Qualifying Stay**

Hospitals will be financially responsible for covered posthospital care required by all discharged Medicare patients, no matter how short their hospital stays have been. The three-day qualifying stay is abolished.

**HCFA's Financial Responsibility**

All Medicare-eligible posthospital care that is not the financial responsibility of any hospital will continue to be reimbursed directly by HCFA on the same basis as it is today.

## **V. SETTING PAYMENT RATES FOR A DEMONSTRATION OF AN EXTENDED PROSPECTIVE PAYMENT SYSTEM**

This section lays out in some detail the possible approaches to setting reimbursement rates to be used in demonstrating an extension to posthospital services of the prospective payment system (PPS) now in use for Medicare hospital reimbursement. It will also discuss the advantages and difficulties of each approach, and note some important uncertainties that could be resolved in the process of setting reimbursement rates. Our concern will be primarily with how existing data can be used to calculate the necessary rates. We will note that these data have some serious drawbacks, but we may not have the leisure to postpone setting rates until more suitable data become available. Thus, obstacles to setting the necessary rates are noted here not as reasons why the exercise should be abandoned, but to make clear the limits of what can be achieved with current data.

### **OBJECTIVES OF THE RATE-SETTING EXERCISE**

In setting reimbursement rates for the proposed demonstration, we seek to achieve a variety of objectives. The first is overall budget neutrality. We should be paying about as much as we would have paid in the absence of any demonstration. Second, the rates should treat participating institutions at least roughly equitably, and should erect no incentive to turn away particular classes of patients for reasons other than a judgment that certain kinds of care are medically unnecessary. Finally, the rates should be perceived as likely to provide an adequate return to participating institutions during the demonstration, nor should any participant be exposed to undue financial risk.

The intent is to pay the hospital enough to cover the expected costs of both hospital and posthospital care required in the course of a particular patient episode. Presumably, this amount will be somewhat larger than the amount currently paid for the costs of hospital care only. If the system is to be budget-neutral, the amount must be roughly equal to the expected costs of the entire episode—including both hospital and posthospital care—under present arrangements. To ensure equitable treatment of institutions serving different patient populations and to ensure that patients with different medical needs have equal access to care, payments will have to be based—just as

current payments for hospital care are based—on some categorization of patients by the type of care they require. To make the extended PPS compatible with the existing hospital-only PPS, this categorization should be essentially the present system of DRGs. To set prospective payment rates for the extended PPS, then, we must calculate the average or expected cost of an entire episode of care for each DRG. These calculations are, of course, more easily described than carried out.

## THE RELEVANCE OF AVAILABLE DATA

The first obstacle to setting reimbursement rates is that there is no truly relevant historical experience on which to base calculations of expected cost. Nowhere has a system like an extended PPS been implemented, and thus no truly appropriate data are available.

Data from the period before the implementation of prospective payment for hospital care (that is, before October 1983) probably reflect an underutilization of posthospital services and an overutilization of hospital services, compared with both current treatment patterns and patterns that would emerge under an extended PPS. Under the old cost-based system of hospital reimbursement, there was little incentive to transfer patients to lower-cost care settings such as nursing homes or home health arrangements. Indeed, there was an incentive to keep the patient in the hospital. It seems likely that the additional cost of the extra hospital days outweighed the savings resulting from reduced use of posthospital services. Probably, then, estimates of costs of an entire patient episode based on pre-PPS data will be higher than the costs of a similar episode either under today's reimbursement arrangements or under an extended PPS. More important for rate-setting, the degree to which pre-PPS data may overstate the costs of a particular episode is likely to vary from one DRG to another. For DRGs where there is little use of posthospital care, the overstatement will be minimal. For the relatively few DRGs, however, where there is potential for substantial use of posthospital care, the overstatement could be large.

Recent changes in the availability of posthospital care also reduce the value of historical data. The past few years have seen rapid growth in the use of home health care, and past experience may be a poor guide to expected future use. This problem is compounded by data reporting logs. At the time that work on this project was begun, the processing of Medicare records necessary to produce usable data on SNF stays had not been completed for stays taking place later than

1982. Calculations reflecting the full posthospital experience of Medicare patients discharged from hospitals in 1982 would have required records of SNF care in 1983, and were therefore impossible.

Given these difficulties, it might seem attractive to base calculations on more recent post-PPS experience. Unfortunately, we again run into serious problems. The first is that we simply do not yet have much data from this period. The last hospitals to convert to the PPS did so only in September 1984, and data on patients discharged from these hospitals became available only in mid-1985. Data on the posthospital care received by these patients will not be complete until mid- or late 1986. The partial data that will be available earlier are likely to be unrepresentative: Data for more complex and costly cases will generally be slower to come in, and these cases will be underrepresented in early samples.

Even if all necessary post-PPS data were at hand, there would still be problems to overcome. Like the pre-PPS experience, the post-PPS experience is not truly representative of what one might expect in an extended PPS. Where the pre-PPS system of reimbursement gave hospitals an incentive to underuse posthospital care, PPS does the reverse. Left unchecked, these new incentives may result in more use of posthospital services than would be the case in an extended PPS. As with pre-PPS experience, this bias will not be uniform across all DRGs.

We are confronted, then, with a set of unpleasant alternatives. Both pre- and post-PPS data are likely to present distorted pictures. For practical purposes, the choice between using pre- or post-PPS data will probably rest on how rapidly reimbursement rates for an extended PPS have to be set. Ideally, we would delay a demonstration until both pre- and post-PPS data were available. By using both sets of data to estimate the appropriate payment rates, we could at least bound the "correct" values. Even if a demonstration will have to go forward on the basis of only pre-PPS data, it now seems unlikely that a decision to implement a full-scale national version of an extended PPS could come before sufficient post-PPS data are available to set reimbursement rates.

## HOW TO CALCULATE REIMBURSEMENT RATES

Implementation of an extended PPS would require paying hospitals an extra amount for the care of each Medicare patient in addition to the amount the hospital already receives for the inpatient component of that patient's care. There are two basic approaches to calculating



this add-on. It could be done directly by calculating the expected cost of posthospital care for a patient in each DRG. Alternatively, we could calculate the expected cost of an entire episode of care—hospital and posthospital—for each DRG and then derive the size of the add-on payment by subtracting the current national payment rate for that DRG from the estimated total episode costs. Either method would produce a “national” add-on payment to cover posthospital costs for a DRG. These add-ons would presumably have to be adjusted (as current DRG payments are) to account for local variations in labor costs and for urban/rural cost differences. Unfortunately, for reasons explained below, neither approach will lead to a truly “correct” set of reimbursement rates. By using both methods, though, we should be able at least to bound the “correct” rates.

We will concern ourselves first with how to calculate national add-ons. More specifically, we will consider how to compute so-called reimbursement “weights,” measures of the relative size of payments that would be made to cover posthospital care for different DRGs, and how these weights would be inflated to provide budget-neutral reimbursement rates. Later we will consider how they might be adjusted to reflect local cost differences.

The simplest approach, from a computational standpoint, would be to choose a sample of Medicare case records from which we would extract the costs of posthospital care. We would then group these cases by DRG, including those cases for which no posthospital care was used, and calculate the average cost of posthospital care in each DRG. Normalizing<sup>1</sup> these costs would provide the necessary weights for add-ons to current DRG payments. These weights (based on outlays for posthospital care in some past base year) would be converted into reimbursement rates for any particular case in the current year by multiplying the appropriate weight by a constant factor. This factor would be the same for all DRGs and would be chosen so as to make total Medicare outlays for posthospital services equal to the outlays expected to have been paid for such services in the absence of an extended PPS.

This approach sounds straightforward enough, but it has some drawbacks. As we noted above, if the sample for these calculations is drawn from pre-PPS data, the result is likely to be an underestimate of the costs of posthospital care in the current environment. Correction of the overall level of reimbursements is a relatively straightforward

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<sup>1</sup>Average costs in each DRG are normalized by dividing each average by the average cost of posthospital care for all DRGs. A DRG for which the average cost of posthospital care is the same as the average cost of such services for all Medicare hospital discharges will have a weight of 1.00. DRGs that tend to have higher (lower) than average posthospital costs will have weights greater than (less than) 1.00.

matter. Rates would be increased sufficiently to make the expected extra outlay for posthospital care roughly equal to what would have been paid for such care without the demonstration.

A more vexing problem is that the rates arrived at by this method for a particular DRG may not be appropriate compared with the rates for other DRGs. This is so because the biases in pre-PPS data are probably not uniform across DRGs. For DRGs in which there is little use for posthospital care, the pre-PPS data are probably not much distorted. For DRGs where posthospital care is a realistic substitute for hospital care, however, the understatement of posthospital costs in pre-PPS data is likely to be greater. The result of using this approach, then, would be a set of reimbursement rates that rewards hospitals liberally for treating patients in those DRGs that do not generally use much posthospital care, and miserly for patients who are likely to need such care. Hospitals can tell the difference between the two, of course, and may be tempted to discriminate against the latter in their admission policies. This problem does not go away if we base our calculations on post-PPS data; the direction of the bias is simply reversed.

There is also a technical drawback to this approach, although one that could be overcome. Medicare billing records for posthospital care do not contain a reliable record of hospital DRG.<sup>2</sup> Since we are contemplating a system that combines both hospital and posthospital costs, payments to hospitals will be based on the DRG recorded for the hospital stay regardless of which DRG is thought to be appropriate for admitting the patient to some form of posthospital care. This means that we must somehow attach to each record of posthospital care the DRG from the relevant episode of hospitalization. This can be done, but requires a matching of hospitalization records with posthospital care records. Files linking records of care in various settings have been compiled in the past for specific projects, but no such files are regularly produced by HCFA, and apparently none have ever been made linking records of hospital, SNF, and home health care.

A final problem is that HCFA records report the charges for posthospital services rather than the costs of providing these services. It would be possible, although tedious, to use cost-reports submitted to HCFA by posthospital providers to convert charges into costs. This procedure was used in the original calculation of reimbursement weights for the hospital PPS. Fortunately, this conversion of charges

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<sup>2</sup>A recent HCFA study reports that, in a sample of SNF records for 1980, the reported admission diagnosis differs from the discharge diagnosis reported by the hospital in two-thirds of the cases. See "The Relationship Between Cost and Case Mix: An Initial Test of a DRG-Based Case Mix Index for Skilled Nursing Facilities," by Phillip Cotterill et al., *Health Care Financing Review* (forthcoming).

into costs is probably unnecessary. A recent study by HCFA<sup>3</sup> has concluded that for hospital reimbursement, weights based on total hospital charges for covered services are little different from weights calculated using only reimbursable costs. The hospital reimbursement weights that became effective in fiscal year 1986 are, in fact, based on total hospital charges. No similar comparison has been performed for posthospital providers, but it would seem appropriate (and easier) to follow the current HCFA practice of using charge-based rather than cost-based weights.

The second possible approach to calculating reimbursement rates has similar theoretical and technical problems. In this approach we would choose a sample of Medicare cases and compute, for each case, the total costs of the entire episode of care—inpatient and posthospital services. After grouping these cases by DRG, we could calculate the expected cost of an entire episode. Normalizing these expected costs would produce base-year weights for reimbursement, which would in turn be multiplied by some factor to produce reimbursement rates for an entire episode of care. As with the first method described above, this multiplicative factor would be chosen to produce budget neutrality: It would be chosen to leave total Medicare outlays for inpatient and posthospital care roughly equal to what they would have been in the absence of an extended PPS. The amount of the posthospital add-on for each DRG would be calculated by subtracting, from the reimbursement for the total episode, the current DRG payment for inpatient care.

The problem is that here again the computation is likely to result in a distorted view of the relative costs of, and therefore appropriate reimbursement rates for, different DRGs. Total episode costs were probably higher in the pre-PPS system for those cases where posthospital care could substitute for hospital care than these costs are under the current PPS. Current hospital DRG rates were calculated using 1984 data. These data are from a time when many hospitals were already operating under the PPS and may therefore reflect lower hospital costs for some DRGs resulting from increased use of posthospital care. Thus, relative reimbursement rates based on the pre-PPS experience of total episode costs will give some advantage to treating patients with conditions amenable to posthospital care and will discourage the treatment of patients for whom such care cannot be substituted for hospital care. As with rates calculated by the first method, the result may be a

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<sup>3</sup>Philip Cotterill, Joel Babula, and Rose Connerton, *A Comparison of Alternative DRG Relative Weights for its Medicare Prospective Payment System*, Office of Research, HCFA, February 1985.



temptation for hospitals to discriminate against certain types of patients.

The technical problem inherent in this approach is the same as that encountered with the first method of calculation. For an accounting of full episode costs, it will be necessary to link together Medicare records of outlays for inpatient care with similar records for SNF and HHA care. As with the first approach to calculating weights, charges for covered services would be used rather than costs in these calculations.

How then to proceed? Both approaches involve technical difficulties; but in both cases these difficulties could be overcome. Neither set of calculations will give us a directly usable set of reimbursement rates. But by calculating the required rates by both methods, we will at least be able to set bounds for these rates. Without undertaking the calculations, there is no way to tell how wide these bounds will be. One can only hope that they will be narrow enough to provide a useful first approximation of the required rates.

## NATIONAL OR SITE-SPECIFIC RATES?

Just as reimbursement rates for the hospital PPS are adjusted to reflect local wage costs and urban/rural cost differences, so would the add-on payments for posthospital care have to be adjusted for these factors. This adjustment is carried out by allowing the multiplicative factor by which weights are converted to actual reimbursement amounts to vary from one area to another; weights, or relative reimbursement rates, remain the same for all hospitals.

The current PPS, however, does not (or will not after a transition period) provide different reimbursement rates reflecting different patterns of practice,<sup>4</sup> and the presumption is that an extended PPS would provide no such adjustments in reimbursement rates either. In a demonstration, though, it will probably be necessary to allow some variation in reimbursement rates, at least from one demonstration site to another. This is because there are today wide variations in the use of posthospital care from one community to another. It seems likely (although it is not certain) that the variations reflect differences in Medicare patients' access to posthospital care. One of the hoped-for benefits of an extended PPS is an improvement in that access in areas where such care is not easily available now. That will not come about quickly, however; the health care community will respond only with a lag to changes in the reimbursement environment. Moreover, it is

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<sup>4</sup>At this writing there is some question about whether the transition to fully "national" reimbursement rates for hospital care will in fact be completed.



possible that a demonstration—by definition a temporary state of affairs—will bring no appreciable change in the availability of posthospital services. Local health authorities, existing hospital and SNFs, and private investors may be reluctant to provide new or different services in the demonstration environment, fearing that that environment will not be permanent. Thus, we are likely to see any demonstration carried out in the face of varied opportunities for and perhaps differing costs of posthospital care. To allow only national, standard rates in these circumstances is likely to produce serious inequity.

Equity will require, then, that reimbursement rates be set during a demonstration to reflect local experiences with posthospital care. Hospitals in demonstration sites with a recent history of little posthospital care utilization should receive smaller add-on payments for such care than do hospitals in areas where the use of such care has been high.

Within a demonstration site, however, it would be better to pay all hospitals equally. To adjust payments to reflect the recent experiences of individual hospitals would be administratively burdensome and technically difficult; individual hospitals simply may not have enough cases on which to base adjustments. More important, hospital-specific rates may jeopardize the demonstration. Hospital-specific adjustment of reimbursement rates is unlikely in a national implementation of an extended PPS, and a demonstration that offered hospitals in the same market different rates of reimbursement for posthospital care might produce behavior rather different from what would occur in a national system.

## CAPITAL COSTS

As is the case with the hospital PPS, capital costs pose a particular problem for an extended PPS. The current PPS allows hospitals to “pass through” capital costs; these costs are directly reimbursed by HCFA in addition to the prospective payments hospitals receive for treating Medicare patients. What is at issue here is how to handle the capital costs of SNFs and HHAs. Are hospitals to be given large enough prospective payments so that in turn they may reimburse posthospital providers for all costs, including capital costs? Or will the capital costs of posthospital providers be separated from their operating costs, with hospitals responsible for only the latter? But who, then, would pay the capital costs of the posthospital providers? Would these costs simply be passed through as hospital capital costs are today? But passed through to whom? Would HCFA reimburse posthospital capital costs through some other mechanism?

There are no completely satisfactory answers to these questions. With the issue of how hospital capital costs will be reimbursed still unresolved in current prospective payment arrangements, there is no straightforward way to deal with the much smaller capital costs of SNFs and HHAs. The best we can hope for in this regard is a workable—if not ideal—arrangement to get us through a demonstration that is likely to take place in an environment that still considers hospital capital costs as direct pass-throughs.

The significance of this issue for the rate-setting exercise is whether or not to include posthospital capital costs along with posthospital operating costs when we perform the rate-setting calculations described above. During the actual course of a demonstration, the resolution of this issue will determine whether providers of posthospital care will have financial recourse to anyone other than the hospital from which a particular patient came and how complex the required cost-accounting system will be.

The simplest approach, both computationally and administratively, would be to include posthospital capital costs with operating costs and make hospitals financially responsible for both. That way, it is possible to set rates without having to separate the various components of posthospital costs, and no special payment mechanism would be required to reimburse capital costs. In adopting this approach, we would be viewing providers of posthospital care simply as providers of a particular service to a hospital, much like the providers of other goods and services. Hospitals are responsible now for the capital costs of their other suppliers; fees charged by food services, laundry services, laboratories, etc., all include some component of capital costs. Why should charges for posthospital care be different?

One of the attractive features of a combined hospital/posthospital PPS is that it would leave hospitals free to adopt the least costly way of providing posthospital care for their patients. Hospitals would be free to establish skilled nursing facilities on their own premises or to establish swing beds for patients needing less intensive care; hospitals could “make” posthospital services. Alternatively, hospitals would be free to “buy” these services from an outside provider. Since HCFA would be paying the same amount to the hospital for the management of the entire patient episode in either case, it would presumably be indifferent to the approach chosen by the hospital.

Care will be required, however, to make sure that the treatment of posthospital capital costs does not influence the make/buy decision. If a hospital “buys” posthospital care, the associated capital costs will have to come out of the prospective payment it receives for the care of a particular patient. If the hospital “makes” posthospital care, and is

allowed to pass through the associated capital costs, the result will be a bias in favor of "making" rather than "buying." In general, hospitals must not be allowed to pass through capital costs associated with "making" posthospital care. For the most part, current regulations are adequate in this regard. The most likely way for a hospital to "make" its own posthospital services would be to establish a so-called separate-part SNF or an affiliated HHA. The capital costs of these kinds of operations are not passed through today, so no change in current practice would be required. If hospitals are allowed to provide skilled nursing care in "swing beds" (see App. C) the capital costs associated with these beds will have to be prorated to reflect the fraction of time they served as acute care beds and the fraction they served as nursing care beds. The portion of capital cost attributed to acute care would be passed through, while the hospital would remain responsible for the portion attributed to nursing care. The accounting required for this arrangement would be no more difficult than the current accounting of the fraction of time that beds are filled by Medicare patients.

Another problem arises with regard to durable medical equipment used during home health care. In a sense, this equipment represents the capital equipment necessary to offer such care. If a patient were in an SNF or a hospital instead of at home, the SNF or hospital would have to buy the necessary oxygen tanks, wheelchairs, special beds, and so on. The rub here is that durable medical equipment is now generally reimbursed under Medicare Part B. (A small share of this equipment—that provided directly by the HHA—is reimbursed under Part A.) If this were to continue in a demonstration of an extended PPS, there might be an unwarranted incentive for hospitals to discharge patients to home health care rather than discharge them to an SNF or keep them in the hospital. This incentive would arise from the ability to get Part B to reimburse at least some of the capital costs associated with treatment if the patient were using home health, but not otherwise. Whether the amounts involved here are large enough to influence decisions is unknown at the moment, but it is something to be looked into. If it turns out that the costs of this durable medical equipment are in fact large enough to be concerned about, then there would seem to be no option but to include them in the rate-setting calculations and to make hospitals responsible for these costs as well. (For more on possible ways of dealing with durable medical equipment in an extended PPS, see App. A.)



## VI. THE ADEQUACY OF CURRENT DRGs AS A BASIS FOR AN EXTENDED PPS

We have already noted that the current set of DRGs provide the only readily available basis for patient classification in an extended PPS. But today's DRGs were certainly not designed with any attention to the costs of posthospital care, and it remains an open question whether they constitute a satisfactory method of patient classification for a payment system that includes both hospital and posthospital care.

Some preliminary work has shown that the current DRGs are not good predictors of posthospital costs.<sup>1</sup> These observations do not necessarily mean that current DRGs are an unsatisfactory basis for an extended PPS. What is relevant is not whether DRGs are good predictors of posthospital costs, but whether they are adequate predictors of total episode costs. Hospitals will be paid an amount that is intended to cover the costs of an entire episode of care, not just the costs of posthospital care. The question to be answered is whether DRGs provide an adequate basis for determining this payment for a full episode. No previous work has dealt with this issue, and some exploration of the subject will be required before embarking on a demonstration that relies on current DRGs as a basis for an extended PPS.

There are two ways in which an inadequacy of current DRGs as a basis for an extended PPS could manifest itself. The first would be high variability in total episode costs within a DRG. If the number of patients treated by a hospital is sufficiently large, random variation in the costs of caring for these patients will not be a problem; over the long run, expensive cases will be balanced by cheap ones. But as the variability of costs rises, more cases are required to give some confidence that variations will wash out. Not all hospitals may have enough cases to allow such confidence. By adding to hospitals' financial liabilities a new category of costs that is badly predicted by DRG, we are likely to increase the variability of costs that hospitals must face. (But not necessarily. It is possible, although unlikely, that for some DRGs

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<sup>1</sup>See, for example, Peter Shaughnessy et al., "Long-Term Care Reimbursement and Regulation: A Study of Cost, Casemix and Quality," Working Paper 4, University of Colorado Health Sciences Center, Denver, Colorado, 1980; Kyung S. Bay, Peggy Leatt, and Shirley M. Stinson, "A Patient Classification System for Long-Term Care," *Medical Care*, Vol. 20, No. 5, May 1982, pp. 468-488; or *Report to Congress: Study of the Skilled Nursing Home Benefit Under Medicare*, Health Care Financing Administration, U.S. Department of Health and Human Services, Office of Policy Analysis, January 1985, pp. 89-95.



the variability of total episode costs may actually be lower than the variability of hospital costs alone.) Thus, we are probably exposing hospitals to greater financial risks by extending the PPS. We make it more likely that either through bad luck or because of a peculiar pattern of admissions, a hospital may find itself with a preponderance of either expensive or cheap cases. Inequitable treatment would be the result.

There is no straightforward answer to the question of how much variability is too much. All we can do is calculate the variability of total episode costs for each DRG with respect to the variability of the hospital costs in that DRG to arrive at some measure of how much extra risk hospitals would be taking on. If the increased risk appears to be only minor, we need not be concerned further. (This is likely to be the case. For most DRGs, posthospital costs will be small compared with inpatient costs. Even very wide variations in posthospital costs within a DRG will constitute only a small change in total episode costs.) If, however, the increase in variability is large, we will probably have no alternative but to devise some way to subdivide affected DRGs in hopes of creating more homogeneous categories.

A more troubling potential problem in using current DRGs as a basis for an extended PPS may arise from nonrandom—or to be more precise, predictable—variations in posthospital costs within a DRG. It is well established, for example, that older patients and patients with emotional disorders are more likely to need posthospital care than are younger patients without emotional disorders.<sup>2</sup> Current DRGs sometimes take account of the age of the patient, but for the most part they do not. They never distinguish among patients on the basis of family status. A variety of other factors not always accounted for in DRGs—the presence of secondary diagnoses, the mental state of the patient, whether or not the patient came to the hospital from a nursing home, and so on—probably also contribute to the likelihood that a patient will require posthospital care.

These observable indications that a patient is likely to require posthospital care may produce some awkward incentives for hospitals. Because hospitals will be responsible for posthospital costs, they will have an incentive to avoid patients who are likely to need more posthospital care than is common, given their DRGs. A hospital is quite likely to know, for example, whether a patient has anyone at

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<sup>2</sup>See Mark R. Meiners and Rosanna M. Coffey, *Hospital DRGs and the Need for Long-Term-Care Services: An Empirical Analysis*, National Center for Health Services Research, December 1984, and Robert L. Kane, Ruth Matthias, and Susan Sampson, "The Risk of Placement in a Nursing Home after Acute Hospitalization," *Medical Care*, Vol. 21, No. 11, November 1983, pp. 1055–1061.

home to assist in his or her care after discharge from the hospital. A patient lacking such assistance is more likely to require posthospital care at the hospital's expense, for which the hospital will receive no extra payment. The hospital might be tempted to deny admission to such patients.

Only a demonstration will reveal how serious a problem these temptations may be. As a preliminary to a demonstration, however, we should look for easily observed factors, such as age and sex, that may explain variations in use of posthospital care within DRGs. When such factors are identified, some consideration should be given to adjusting current DRGs—probably by splitting current DRGs—to take these factors into account. Unfortunately, regularly collected HCFA data do not provide information about some of the factors that appear to be the most powerful determinants of whether posthospital care will be required—mental condition, for example. There is probably no way to assess the effects of these factors except by gathering more complete data in special surveys. This might be possible in a few demonstration sites during the course of the demonstration.

## VII. REGIONAL VARIATIONS IN ACCESS TO POSTHOSPITAL CARE

An extended prospective payment system (PPS) would be most easily managed if payment rates were uniform for all hospitals covered by the system. Equity will demand, however, some variation in payment rates to account for factors beyond the control of individual hospitals. The current PPS, for example, allows reimbursement rates to reflect differences in local wage costs, and urban/rural cost differences; an extended PPS would presumably do likewise.

Not all cost differences are to be taken into account in setting prospective reimbursement rates, however. Costs may vary from one hospital to another because of differences in prevailing patterns of medical practice. In implementing the hospital PPS, Congress did not allow reimbursement rates to vary as a function of different patterns of practice. After a transition period, all hospitals with similar wage costs are to be reimbursed equally for similar cases, no matter what their previous cost histories may have been.<sup>1</sup> In part, this reflects a judgment that differences in patterns of care are not to be perpetuated and therefore that reimbursement policies should not allow for such differences. In part, it reflects the impossibility of devising a method to adjust for the costs of differing patterns of treatment that would not end up rewarding past inefficient care and penalizing past efficiency. Presumably, no corrections for differing patterns of care will be made in an extended PPS.

The general rule seems to be that unalterable, "legitimate" cost differences that are beyond the control of individual hospitals should be reflected in reimbursement rates. On the other hand, cost differences that can be reduced or eliminated, that arise from undesirable or unnecessary differences in the level of care, or that reflect differences in the efficiency with which care is provided, do not constitute a justification for varying reimbursement rates.

How to apply this general rule to differences in the availability of posthospital care is unclear. Hospitals with only limited access to posthospital care may legitimately claim that they face systematically higher costs than do more favorably situated hospitals. The former hospitals cannot take full advantage of the cost-saving possibilities of

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<sup>1</sup>The wisdom of making a full transition to "national" payment rates has been challenged, and there is now some uncertainty about whether this transition will ever be completed.



transferring patients to lower-cost SNF or home health settings. They therefore might quite justifiably claim a higher rate of reimbursement than is paid to hospitals with ready access to this sort of care. Similarly, hospitals that have good access to posthospital care and use it heavily might legitimately claim larger add-on payments in an extended PPS, because they will obviously be taking on a larger additional financial burden.

These claims raise three practical questions. First, how are we to determine whether the patients of a particular hospital, or the patients of hospitals in a particular region, do in fact have different access to posthospital care than do patients of other hospitals or in other regions? Second, are any such differences unalterable? For example, could a new method of reimbursement for posthospital care eliminate these differences and thereby eliminate the need for any adjustment in reimbursement rates? Finally, if the differences are unalterable, what is to be done about them in an extended PPS?

There is strong circumstantial evidence that access to posthospital care does differ greatly from one area to another, although we have no systematic way to measure the differences, nor do we have solid evidence on their causes. Consequently, we are unsure whether a new method of reimbursement might reduce or eliminate these differences. Further, since we do not well understand what is behind these apparent differences in access, it is impossible to say whether they should be allowed to persist. Available evidence does suggest that at least some of these differences arise from features of present Medicare policies toward posthospital care and could therefore be relieved by adjustments in this system.<sup>2</sup> The extent to which revised reimbursement policies can bring "adequate" access to posthospital care for all Medicare patients remains unknown. This issue will be an important focus of any demonstration of an extended PPS.

## THE EVIDENCE

There is little solid information about access to posthospital care. Anecdotal evidence strongly suggests that it is often difficult to place Medicare patients in skilled nursing facilities, but little is known about the relative difficulty of placing such patients in different regions. We know even less about access to home health care; a search has turned up no literature at all on the subject. The home health care industry

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<sup>2</sup>For a summary of this evidence, see *Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, Health Care Financing Administration, U.S. Department of Health and Human Services, January 1985, especially Chap. 3.



has grown rapidly in the past few years, however, and one does not hear that it is particularly difficult to arrange home health services for Medicare patients. The prevailing view seems to be that access to home health care is seldom a problem, and that the rapid expansion of home health services may have relieved at least somewhat the pressure on SNFs to admit more Medicare patients.

The central difficulty here is that there is no way of observing SNF access directly. The best we can do is to observe use. Some useful data on the use of SNF services by Medicare patients were gathered by Feder and Scanlon for their 1981 working paper.<sup>3</sup> Their data, for the years 1978 and 1979, are somewhat out of date but seem to be the best available.

Use of SNF services by Medicare beneficiaries varies enormously across states. Feder and Scanlon report that, in 1979, Medicare covered 326 days of SNF care for every 1000 persons nationwide aged 65 or over. In Hawaii, however, the figure was 691 days, while in Mississippi it was only 58 days—one-twelfth the rate in Hawaii. This is not the result of statistical “outliers”—distorted use-patterns in just a few states. Even if we exclude the ten states showing the highest use and the ten showing the lowest, utilization rates still vary by a factor of three. The picture is similar if we consider the number of Medicare patients admitted to SNFs. In 1978, there were 11.2 Medicare users of SNF services nationwide for every 1000 persons 65 or over. In Nevada the rate was 21.2, but in Arkansas only 1.8. Once again, utilization varies: by a factor of 12 across the states.

These statistics, while striking, are flawed because they take no account of demographic variation among the states or of the differing incidence of various diseases. We know of no previous exhaustive comparisons across states of the likelihood that a Medicare patient with a particular condition will be treated in an SNF. In an internal study, HCFA has performed such calculations for three diagnoses which together account for a large share of SNF admissions. In 1980, a Medicare patient discharged from a hospital in Rhode Island with a fractured femur was twenty times more likely to receive SNF care than would a similar patient in Mississippi. For stroke victims, the likelihood of SNF care was also twenty times greater in the state showing the highest utilization (Hawaii) than it was in the state showing the lowest (Mississippi). And for cancer patients, the likelihood was 34 times greater in Hawaii than in New Mexico.

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<sup>3</sup>Judith Feder and William Scanlon, *Medicare and Medicaid Patients' Access to Skilled Nursing Facilities*, Working Paper 1438-02, The Urban Institute, Washington, D.C., November 1981.

It is difficult to believe that these enormous differences are due only to varying styles of medical practice or to differences in the health or demographic status of the population. Taken together with the persistent stories of how hard it is in some areas to place Medicare patients in SNFs, it seems almost certain that Medicare patients' access to SNF care must be extremely restricted in some cases. This is not necessarily the same thing as saying that Medicare patients' access to *all* posthospital care is sharply restricted in some states. It is possible, although perhaps not likely, that patients who cannot obtain SNF services are able to find home health services that represent a reasonable substitute for SNF care.

Pending further study, we must conclude that the few data we have suggest important regional variations in access to posthospital care. We therefore must consider whether either a demonstration or a nationwide implementation of an extended PPS must adjust for these differences.

## **WHY THERE ARE DIFFERENCES IN ACCESS TO POSTHOSPITAL CARE**

These seem to be two basic reasons why access to posthospital care may vary from place to place: Some areas simply may not have facilities or institutions capable of providing posthospital care; and in others, existing institutions may be unwilling to participate in the Medicare program, or, having decided to participate, are sometimes reluctant to treat Medicare patients. We will discuss each of these reasons in turn and consider what each might imply for an extended PPS. As was the case with utilization, very little is known about the availability of HHAs and their willingness to treat Medicare patients.

### **The Absence of SNFs in Some Locales**

Some Medicare patients are denied access to SNF care simply because there is no SNF nearby. Feder and Scanlon estimated in 1981 that 13 percent of the elderly resided in counties that had no skilled nursing facilities.<sup>4</sup> Of course, facilities in neighboring counties are often available, and although it is impossible to estimate precisely what fraction of Medicare patients are denied access to a SNF solely by reason of their location, the relevant fraction is presumably much lower than 13 percent.

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<sup>4</sup>Ibid.

Neither a demonstration nor full implementation of an extended PPS is likely to create SNFs where they do not exist today. Medicare patients account for only a small fraction of total nursing home revenues (around 2 percent) and even a doubling or trebling of Medicare SNF utilization is unlikely to justify the construction of new facilities in regions that now have none.

For some patients, home health care may be an appropriate substitute for SNF care. HHAs require little capital to begin operation; and in an extended PPS, hospitals seeking an alternative to maintaining patients in a high-cost inpatient setting may choose to establish their own HHAs. Thus, one response to an inadequate supply of SNF services may be the expansion of home health services. The substitution of home health care for SNF care may be further encouraged by the loosening of some current Medicare regulations. In an extended PPS, a hospital would receive a fixed payment for the care of a patient, and it would therefore be a matter of indifference to HCFA if the hospital chose to provide a patient with more or different home health services than are covered under current Medicare policies. Perhaps by providing some extra services (homemaker services, for example), a hospital could discharge to home health a patient who under today's rules would have to be cared for in an SNF. Hospitals could also compensate for the absence of SNFs by operating some of their capacity as "swing beds," beds available either for customary inpatient care or with reduced staffing levels for skilled nursing care. Rural hospitals are already permitted to operate swing beds. Since it is generally rural areas that lack SNFs, one potential mechanism for overcoming a shortage of SNF services is already in place.

Despite possibilities for substituting home health care and swing beds for missing SNFs, there will almost certainly be some areas in which adequate posthospital care (and particularly SNF care) will remain unavailable. In these areas, hospitals will have little choice but to keep patients in high-cost hospital settings until they can be discharged to self-care. These hospitals will necessarily face somewhat higher costs than will more favorably situated hospitals and therefore might legitimately seek higher rates of reimbursement.

### **Reluctance of Nursing Homes to Treat Medicare Patients**

While some Medicare patients are doubtless denied skilled nursing care simply because there is no suitable facility nearby, the major concern for most Medicare patients is not the existence of skilled nursing facilities, but whether local facilities will accept them as patients. Few



nursing homes depend on Medicare patients for their financial well-being. Medicaid and private-pay patients are much more important to most nursing homes, whose willingness to accept Medicare patients depends heavily on their attractiveness relative to Medicaid patients, the local demand for SNF services by Medicaid and private-pay patients, and the extra requirements for Medicare certification beyond what is required for state Medicaid certification. In short, access to SNF care by Medicare patients will depend heavily on the nature of state regulation and Medicaid programs. While the federal government has the power to regulate state Medicaid programs, no attempt to alter Medicaid rules simply to provide more even access to SNFs by Medicare patients seems likely. (Neither would it be wise, since we have no clear understanding of how particular features of state Medicaid programs affect the willingness of SNFs to accept Medicare patients.) Thus, efforts to guarantee adequate access to SNF care for all Medicare patients will have to focus on making these patients more attractive to SNFs. An extended PPS might have this result.

In some respects, Medicare patients are already attractive to SNF operators. In most states, for example, Medicare reimbursement for routine SNF care is higher than Medicaid reimbursement for similar care. Further, since Medicare patients often become private-pay patients when they have exhausted their Medicare benefits, treating Medicare patients can be a profitable strategy for some SNFs.

Counterbalancing these benefits, and apparently often outweighing them, are other features of Medicare reimbursement arrangements that discourage SNFs from treating Medicare patients. The most troublesome is the retrospective and often unpredictable determination by Medicare fiscal intermediaries of what SNF services are covered under Medicare. SNFs complain that they sometimes provide care to a Medicare patient only to have some of the costs disallowed—often after the patient has left and there is little hope of collecting additional amounts from him. As long as these disallowed claims do not exceed 5 percent of the total Medicare days claimed by the SNF in the previous quarter, current Medicare policy is to provide reimbursement for disallowed charges if the errors were made in good faith. But for facilities treating only a few Medicare patients, one or two mistakes is all it takes to exceed this threshold. Many SNFs apparently refrain from filing questionable claims rather than risk losing their protection against what many regard as the essentially arbitrary decisions of Medicare fiscal intermediaries. In contrast, with most state Medicaid programs, SNFs generally know from the outset how much and for what they will be paid.



In an extended PPS, Medicare intermediaries would have much less to say about whether particular charges were allowable or not. SNFs would negotiate directly with hospitals in setting payment policies. If a hospital will not agree to a straightforward and predictable method for reimbursement, the SNF is free to refuse its patients. Since Medicare patients are usually only a small part of an SNF's case load, this refusal may hurt the hospital more than the SNF. SNFs, then, might have bargaining power in dealing with hospitals; they have none in dealing with a Medicare financial intermediary.

Another obstacle to SNF participation in the Medicare program is the detailed cost accounting required by Medicare. In most states, the Medicaid program does not require such detailed accounting, and SNFs are understandably reluctant to keep the kinds of records necessary for Medicare reimbursement if Medicare patients make up only a small fraction of their patient load. In an extended PPS system, SNFs would deal with individual hospitals rather than with Medicare fiscal intermediaries, and they would be free to work out reimbursement arrangements that did not require such detailed cost accounting. This ought to be easily negotiated; it is unlikely that hospitals would be any more eager to receive detailed cost accounts than SNFs would be to produce them.

A third common complaint about Medicare reimbursement for SNF care is that it takes no account of the level of care a patient actually requires. Ancillary services provided to Medicare patients are reimbursed separately, but basic daily care is reimbursed at the average rate for all patients in a facility. It is widely alleged that Medicare patients require more care on average than do other patients and therefore that Medicare reimbursement is often inadequate. (To get around this sort of problem, SNFs sometimes set up a separate unit that treats only Medicare patients. The average cost of a day of care in this unit is higher than in the rest of the SNF, and current Medicare regulations allow reimbursement at the higher average rate of the special unit.) Some observers claim that this situation has been aggravated by the institution of prospective payment for hospitals, which encourages hospitals to discharge their Medicare patients to SNFs "quicker and sicker." The failure of current Medicare policies to distinguish among patients according to the costs of their daily care requirements also encourages "creaming" by SNFs—accepting only those Medicare patients who need relatively little daily care. The result of this is difficulty in finding SNF beds for Medicare patients who require unusually extensive posthospital care. The freedom of SNFs to negotiate payment arrangements with individual hospitals should go some way toward alleviating these problems. Both hospitals and SNFs will have

an incentive to devise payment arrangements that allow for the easy transfer of patients, and the freedom provided by an extended PPS will allow SNFs and hospitals to negotiate rates of reimbursement for different levels of SNF care.

A final reason sometimes cited for SNF unwillingness to participate in the Medicare program cannot be eliminated by an extended PPS. To receive Medicare reimbursement, an SNF must be certified as meeting certain federal standards. These same standards apply to SNFs seeking reimbursement for Medicaid. A difference arises, however, in the agency that grants the certification. Medicare certification is always done by the relevant HCFA regional office. Medicaid certification is usually done by state authorities. While the standards for both kinds of certification are the same, it is alleged that some state authorities are more flexible in interpreting these standards than are the HCFA regional offices. Thus, some SNFs may find it easier to seek only Medicaid certification, not both kinds. Opinions differ as to whether these considerations really influence nursing home behavior. The requirement for Medicare certification would surely continue in an extended PPS, and there would be no reduction in whatever disincentives to participate in the Medicare program may arise from differences in certifying agencies.

## ACCESS VERSUS USE

It seems unlikely that differences in access to posthospital care alone can explain the enormous observed variation in use of these services. Other studies have found widely varying patterns of medical care<sup>5</sup> when there is no reason to suspect that differences in access to certain kinds of care are the cause. One suspects that at least a part of the varied use of posthospital care is similarly due to differences in the way medicine is practiced in different areas. Simply making access to posthospital care equal in all areas will not therefore eliminate variations in use. Since we do not understand what lies behind variations in practice patterns, there is no way to guess whether or not an extended PPS would reduce or eliminate them. Perhaps a demonstration would shed some light on these issues.

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<sup>5</sup>See, for example, John E. Wennberg and Alan Gittlesohn, "Variations in Medical Care Among Small Areas," *Scientific American*, Vol. 246, No. 4, April 1982, pp. 120-134.

## HOW TO PROCEED

We are not yet in a position to make firm judgments about whether a nationwide extension of the current PPS to posthospital care is feasible without some special account being taken of the uneven availability of posthospital services among communities. Our understanding of how much SNF care is available to Medicare patients and what influences this availability is obviously incomplete. We know almost nothing about these issues with regard to HHAs. Where do we go from here?

Certainly, more basic research is possible. The empirical work necessary to design a demonstration of an extended PPS will require the collection of a large sample of Medicare patient histories covering entire episodes of illness. This sample will allow the first analyses of use patterns in posthospital care that are fully adjusted for diagnosis and that place the use of particular kinds of posthospital care in the context of care from other sources. Analysis of this sample should allow us to confirm, or to modify if necessary, our tentative conclusion that utilization—and presumably access—vary dramatically by region. We may also gain some further insight into the causes by combining the evidence in this sample with, for example, information about local Medicaid programs. This sample will also provide the first opportunity to explore the substitutability of home health care and SNF care. Do areas that show low use of SNF services by Medicare patients also exhibit high use of home health care? If home health care appears to be a reasonable substitute for SNF care for some diagnoses, then hospitals in areas that have few SNF beds may still be able to provide useful and cost-effective posthospital care for their patients by using existing HHAs or setting up their own. But no amount of work with past data will allow much progress on the really central issue regarding Medicare access to posthospital care: Can a different payment mechanism for posthospital care make existing providers more willing to care for Medicare patients? There is no other way to explore this question than through a demonstration.

As we have noted, a change in Medicare payment policies for posthospital care is not likely to bring about the establishment of new SNFs. The Medicare demand for SNF services is simply too small compared with demand from Medicaid and private-pay patients. Even if some new SNF beds would be built after the implementation of a national extended PPS, we would not expect to see the installation of permanent new capacity during a demonstration, which is by definition a temporary set of policies. Home health agencies are much easier to establish, and we might see some new activity in this field during a



demonstration. The main focus of the demonstration, however, will be on the behavior of existing institutions. Do they become more willing to admit Medicare patients? We should therefore seek to run the demonstration in areas that are already well supplied with nursing-home beds and with HHAs, whether or not these institutions are currently providing care to many Medicare patients. If low-use areas increase their use-rates during the demonstration, then the new payment method does in fact reduce barriers to the treatment of Medicare patients. This evidence will be more compelling if areas with no problems of access do *not* show similar increases. The import of these findings for a national extension of the PPS is that, if changes in the payment method can expand the use of posthospital care in areas where it has been difficult to arrange, we may not have to be concerned with adjusting for differences in access.

Should reimbursement rates used during the demonstration be adjusted in any way to reflect differences in the availability of posthospital care? To calculate appropriate additional payments to cover posthospital costs for each DRG, for each individual participating hospital, would be impossible given the few cases that any one hospital is likely to see in a particular DRG. We are forced, therefore, to make additional payments for a particular DRG uniform for all hospitals within a metropolitan area or within a state. This approach probably represents a fair approximation of equity, since most hospitals in an area ought to have or ought to be able to arrange roughly equal access to local posthospital care facilities.

But as we noted in the preceding section, a desire for equity during a demonstration suggests that these additional payments should vary from one general demonstration area to another. We will, after all, be requiring hospitals to assume new financial responsibilities, and additional reimbursement at some national average rate will not cover the additional outlays of hospitals that make heavy use of posthospital service. Conversely, hospitals in areas with little use of posthospital services will receive a windfall—add-on payments that exceed the cost of their new responsibilities.

This approach may be appropriate during a demonstration, when our aim is to give no participating hospital an unnecessary windfall or to force any hospital to bear unnecessarily high costs. In a full-scale implementation of an extended PPS, however, equity may demand a different approach. Consider the case of a hospital in an area where access to posthospital care is restricted. This hospital will not be able to make use of the most cost-effective mix of treatment settings. Its total costs for providing care are likely to be higher than those of hospitals that have ready access to posthospital care, and this hospital



might reasonably ask that its reimbursement reflect the disparity. Note, however, that an add-on payment based on local experience with the use of posthospital care would provide this hospital a lower total reimbursement than would be offered to a hospital with easy access and therefore heavy past use of posthospital care. The system of add-on payments proposed for the demonstration, then, is perverse. It pays more to hospitals who are lucky enough to be able to transfer patients to less expensive settings, while penalizing hospitals that are not so lucky.

This problem arises not because of the nature of the extended PPS, but because of the nature of the present PPS for hospital care only. The extra costs that a hospital faces because it has only limited access to posthospital care are likely to show up as extra *hospital* costs. Because patients cannot be transferred to other settings, they must remain in the hospital. Since the current PPS does not recognize these cost differences (or, more correctly, will not recognize them after the end of the transition period) hospitals without access to posthospital care are penalized under existing arrangements.

To adjust reimbursements fully and fairly for differences in the availability of posthospital care, it would be necessary for payment rates to reflect regional differences in the costs of care for an entire episode, not merely for posthospital care. Whether this sort of adjustment is likely, though, remains in question. The current PPS refuses to recognize regional differences in the cost of inpatient care except insofar as they arise from differences in wage rates. Hospital costs account for 95 percent of Medicare Part A outlays. Extending the current PPS system to posthospital care may make local differences in the availability of services more visible, but one might wonder whether this extension alone will justify more thorough regional differentiation of reimbursement rates.

Ironically, if no adjustment is to be made for regional differences in the costs of hospital care, ignoring regional differences in the costs of posthospital care will actually reduce inequity in the PPS. Uniform add-ons for all hospitals would have the effect of paying more for posthospital care than is actually spent for it by hospitals that have trouble placing patients in such settings. This overpayment would go some way toward compensating these hospitals for the underpayment of their above-average hospital costs in the inpatient part of the extended PPS. Similarly, hospitals with good access to posthospital care would find themselves paying out more for these services than they were receiving in add-on payments. Thus they would be giving back part of the windfall they gain as a result of their below-average costs for hospital care.

This leads us to a curious conclusion in designing an extended PPS. What are we to do if we discover legitimate, unalterable differences in access to posthospital care? The answer seems to be that we should ignore them. The inequities caused by these differences are already in the present system; by ignoring them in building an extended PPS, we actually reduce them.

## VIII. ADMINISTRATIVE CONSIDERATIONS

Among the aims of an extended prospective payment system is some reduction of the burden borne by health care providers, by HCFA, by fiscal intermediaries, and by peer review organizations in administering the Medicare reimbursement system. Some current administrative requirements could be eliminated in an extended PPS, and some new administrative concerns may arise.

### COPAYMENT AND BAD DEBT

One objective in designing an extended PPS is to leave the total Medicare benefit package as nearly unchanged as possible. To do so will require that an extended PPS incorporate the patient copayments now required for SNF care. There is no similar problem with home health care because unlimited amounts of home health care are allowed without any patient copayment (except for durable medical equipment).

The current Medicare SNF benefit provides 20 days of free SNF care to a Medicare beneficiary during a benefit period. For the 21st through the 100th day of SNF care, the beneficiary is responsible for a substantial copayment. The daily copayment rate is set equal to one-eighth of the prevailing deductible amount for Medicare inpatient hospital services. Table 8.1 shows the required daily copayment amount and the average SNF per diem cost for Medicare patients in recent years. Beyond 100 days, the beneficiary must pay all SNF costs. Under present arrangements, the SNF is responsible for trying to collect these copayments. SNFs are reimbursed retrospectively by HCFA for copayments that remain uncollected after reasonable efforts on the part of the SNF.

Presumably, an extended PPS would make no change in the copayments required of patients. The overall approach to these copayments would be similar to the approach taken now with respect to required copayments for hospital services. The prospectively determined reimbursement rate for a case in the present PPS represents, and in the proposed extended PPS would represent, the maximum revenue that the hospital could earn for providing covered services to a beneficiary in a particular DRG. Actual reimbursement from HCFA to the provider of care is the established DRG rate less whatever amounts are due from the patient in the form of deductibles and copayments.

Today, the hospital is responsible for collecting patient copayments for inpatient care. Whether the hospital will be responsible also for



Table 8.1  
REQUIRED DAILY COPAYMENTS FOR MEDICARE SNF  
CARE AND AVERAGE PER DIEM COSTS FOR  
MEDICARE SNF CARE,  
1975-1986

<i>Year</i>	<i>Copayment</i>	<i>Average Cost</i>
1975	\$11.50	\$31.31
1976	13.00	33.46
1977	15.50	37.59
1978	18.00	38.64
1979	20.00	43.60
1980	22.50	47.03
1981	25.50	51.64
1982	32.50	54.04
1983	38.00	56.75
1984	44.50	N.A.
1985	50.00	N.A.
1986	61.50	N.A.

*SOURCES:* For copayments: *Code of Federal Regulations*, Title 42, Chap. IV, Sec. 409.85; and *Federal Register*, September 1985, p. 39940. For average costs: *Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, Health Care Financing Administration, U.S. Department of Health and Human Services, January 1985, p. 26.

NOTE: N.A. = not available.

copayments for posthospital care in an extended PPS will depend largely on what limitations are placed on the hospital's financial liability for posthospital care. (See Sec. IV for a full discussion of alternative definitions of hospital liabilities.) If hospitals are to be financially responsible for all Medicare-covered SNF services (as in the "maximalist" alternative discussed in Sec. IV), then it would seem logical for hospitals to bear responsibility for collecting copayments for SNF care. This would eliminate any need for SNFs to deal directly with HCFA. All of their reimbursement would come from the hospital. The freedom accorded to hospitals and SNFs to arrive at mutually acceptable agreements would allow hospitals to make arrangements for SNFs to aid them in collecting copayments if this seemed attractive. But in HCFA's view, these copayments would be the ultimate responsibility of the hospitals, and thus it would be hospitals that could claim compensation for bad debts.

If, on the other hand, hospitals are financially responsible for only the first 20 days of Medicare-covered SNF care (as in the "minimalist" definition of hospital responsibilities in Sec. IV), it would not make sense for the hospital to be responsible for collecting copayments for SNF care. None of these payments would be incurred during the period of the hospital's responsibility. Further, since the SNF would have to apply directly to HCFA for reimbursement for the costs of care beyond the 20th day, the SNF could just as well apply for reimbursement for uncollected copayments.

## **MEDICARE-MANDATED COST REPORTING**

One of the reasons sometimes cited for the unwillingness of nursing homes to accept Medicare patients is the allegedly burdensome cost-reporting that HCFA requires. Because Medicare patients are unlikely ever to account for more than a very small share of total revenue in many nursing homes, the cost of setting up the accounting procedures necessary to meet Medicare requirements is not justified by the potential increase in revenues. If hospitals are responsible for all Medicare-covered SNF care, then SNFs will have no reason to deal directly with HCFA. All reimbursement for care provided to Medicare patients will come from hospitals, who are likely to be less concerned about extensive cost-reporting than HCFA must be. (It seems unlikely that hospitals could absorb the kind of accounting detail that HCFA now requires of SNFs.) Left to their own devices, hospitals and SNFs would most likely develop payment mechanisms that do not depend on extensive cost-reporting, and SNFs would be relieved of Medicare-mandated cost-reporting. If, however, hospitals are financially responsible for only a portion of SNF care received by Medicare beneficiaries, SNFs will presumably still have to file Medicare cost-reports in order to justify the payments they will receive directly from HCFA.

Reporting requirements for HHAs will not change in an extended PPS. Under current Medicare regulations, a prior hospital stay is not a requirement for home health benefits. This would presumably not be changed in an extended PPS, and HHAs would have to seek reimbursement directly from HCFA for services provided to patients who had no prior hospital stay. This reimbursement would be provided on the same basis as it is today, and thus HHAs would have to maintain the same cost-reporting arrangements that they have with HCFA today. Such arrangements will also be necessary for reimbursement of home health care that extends beyond the limits of hospital responsibility.

## FISCAL INTERMEDIARIES AND ELIGIBILITY FOR BENEFITS

Under present Medicare arrangements, fiscal intermediaries must review all claims for posthospital care reimbursement to determine whether beneficiaries are eligible for such care and whether the care provided satisfies Medicare definitions for covered care. Denials are common, as in fiscal year 1982, when 33.5 percent of SNF claims were denied.<sup>1</sup> That often happens after care has been provided, and providers are left to try to collect from patients, who sometimes have already been discharged. This situation is commonly cited as a reason for SNFs' reluctance to accept Medicare patients.

An extended PPS could relieve these problems to some degree. Fiscal intermediaries would still have to monitor eligibility; and they would still have to respond to queries from providers about the number of SNF days that a patient had already used in an illness episode. But since the hospital would have financial responsibility for the patient's SNF care, these inquiries could be (and probably would be) lodged at the time of the patient's admission to the hospital. The hospital would already be inquiring into the patient's eligibility for hospital care, and it would be a simple matter to include information on his eligibility for SNF care. Thus, any problems of eligibility would most likely be discovered at the outset.

The need for the fiscal intermediary to review a beneficiary's care in a posthospital setting would be greatly reduced. Today, the intermediary must confirm that such care meets Medicare definitions of skilled care. Judgments on these issues are necessarily subjective, and both anecdotal evidence and formal studies suggest that these rulings can be erratic and unpredictable.<sup>2</sup> But with an extended PPS, the primary responsibility for assuring that only necessary and appropriate care is provided to patients in a posthospital setting would fall on individual hospitals. Variations in the amount of posthospital care provided would not affect outlays by HCFA, and thus there would be little need for fiscal intermediaries to concern themselves with whether the care provided satisfied particular conditions.

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<sup>1</sup>*Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, U.S. Department of Health and Human Services, January 1985, p. 68.

<sup>2</sup>Helen L. Smits, Judith Feder, and William Scanlon, "Medicare's Nursing Home Benefit: Variations in Interpretation," *The New England Journal of Medicine*, Vol. 307, No. 14, September 30, 1982, pp. 855-862.



## PEER REVIEW AND QUALITY ASSURANCE

In an extended PPS, peer review organizations (PROs) would continue to review hospital admissions and verify DRGs to prevent fraudulent claims for Medicare reimbursement, but there will be little reason for PRO review of transfers to posthospital care to verify that such care is necessary. Presumably, the hospital paying for it will take on that chore willingly. More to the point, if excessive posthospital care is provided, the hospital—not Medicare—is at risk. The primary roles for PROs with respect to posthospital care will be quality assurance and the adjudication of disputes between hospitals and posthospital providers.

The quality assurance role as it relates to posthospital care will be similar to the same role as it relates to inpatient hospital care in the present PPS. Under both systems, there is an incentive to limit the care provided to a patient, and some measures will be required to guarantee that the quality of care meets certain standards. The PRO program has been established only recently (hospitals had until October 1984 to contract with PROs for review of their activities), and it remains to be seen by what specific mechanisms, and how effectively, these organizations will monitor the quality of inpatient care.<sup>3</sup> An extension of the PPS will undoubtedly increase the scope of PRO quality assurance activities: PROs will have to monitor quality of care for an entire episode of care instead of for a hospital episode alone. New procedures will undoubtedly be required, but the differences between necessary quality assurance measures in an extended PPS and in the current hospital-only version seem likely to be more of degree than of kind. Procedures for reviewing quality of care and for investigating allegedly poor quality of care that are developed for the hospital-only PPS should be transferable, at least in their general form, to an extended PPS. How well PROs can handle these expanded responsibilities can be tested only through a demonstration.

A completely new function for PROs may arise out of the need for a mechanism to settle disputes between hospitals and posthospital providers. Inevitably, in an extended PPS, differences of opinion will arise between, say, a nursing home and a hospital about the level of care a patient requires or about whether a patient can be safely discharged. These disagreements may be due to different incentives facing posthospital providers and hospitals. A hospital may, for example, be paying a posthospital provider on a per diem or fee-for-service basis, while the hospital itself is receiving a fixed total payment for a

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<sup>3</sup>Kathleen N. Lohr and Robert H. Brook, *Quality Assurance in Medicine: Experience in the Public Sector*, The Rand Corporation, R-3193-HHS, October 1984.

case—a situation that may well color the two parties' views about a patient's proper level of care or length of stay. Disputes may also arise out of simple differences of opinion about the best care for a patient. If posthospital providers are to retain any independence, the hospital cannot be allowed to dictate to them in all cases. The hospital may be wrong anyway, since it may not be able to monitor a patient's condition once he has left the hospital. Disputes over the need for care and the level of care seem to fall naturally within the province of a PRO.

Disputes are likely to diminish as participants get used to the workings of an extended PPS and establish harmonious relationships. Hospitals and posthospital providers with similar views on care are likely to be drawn to each other and develop trust in each other's judgment.

## IX. DEMONSTRATION OBJECTIVES AND THEIR DESIGN IMPLICATIONS

We now turn to the design of a demonstration, the reasons one might be desirable, and what variations in the design might be demonstrated. Section X will consider issues related to participation, and Sec. XI will discuss such features as the desirable number of sites, duration of the demonstration, and operational options.

### WHY A DEMONSTRATION?

A demonstration of an extended PPS will be a major undertaking, probably requiring upwards of four years. Scores of hospitals will have to be enrolled, and thousands of patients will be affected, many of whose experiences will have to be recorded and analyzed in detail. The costs cannot be calculated exactly as yet, but they are certain to run into the millions of dollars. The question is inescapable: Why a demonstration at all?

We can offer no definitive answer; no amount of analysis ever can. The decision on whether to proceed will be up to the authorities. Here, we offer some considerations that should influence the decision.

Perhaps the most powerful argument against the demonstration is that it simply may not be worth it. Medicare outlays for SNF and home health care account for only about 5 percent of total Part A outlays. Outlays for truly *posthospital* care in these settings are smaller, probably about 3 percent of total outlays. Only about 11 percent of Medicare hospital discharges (at least in the pre-PPS period) are followed by SNF or HHA care. Can we really expect that the benefits of an extended PPS will justify a long and expensive demonstration?

There is no way to answer this question today, because we have no experience with systems that in any way resemble an extended PPS. We argued above that any significant gains from an extended PPS would arise from more efficient management of entire episodes of patient care, not from the more efficient provision of posthospital services alone. But what kinds of efficiency gains are possible cannot be estimated now. It is, of course, to answer this question that a demonstration is proposed in the first place.



Even if the demonstration promised to provide useful information, one might also ask whether the current hospital PPS is likely to survive in anything like its present form after several years in the demonstration. Many proposals for altering the hospital PPS are currently being discussed. Some suggest that it will shortly give way to some form of capitation arrangement. If so, the question is, why bother to demonstrate an extension of a system that may be gone before we can apply what we learned.

Speculation about the future of the hospital PPS is beyond the scope of this report and probably fruitless anyway. Assessments of the prospects for the current PPS are best left to officials at HCFA and elsewhere in the government—the same officials who will eventually have to decide whether to proceed with a demonstration of an extended PPS.

One might also object that a demonstration is unnecessary because, after all, we could explore some important questions using currently available data: Can reimbursement rates be calculated? Are current DRGs an adequate basis for an extended PPS? Will an extended PPS expose hospitals to unacceptable financial risk? Will an extended PPS encourage patient “skimming” or “dumping”? None of these questions can be answered completely with existing data, but we can at least test the basic distributional and financial consequences of an extended PPS. If these preliminary analyses turn up no major obstacles to extending the PPS, so goes the argument, why not proceed immediately with a nationwide implementation without incurring the costs and the delays of a demonstration? The proposed extension is, after all, a rather minor change in the overall PPS. More important, the entire PPS will be subject to continual refinement and correction. Problems that arise as a result of the extension to posthospital care can be handled in the same way that problems with the acute-care PPS are handled.

Such objections sound reasonable on the surface, but implementing a nationwide extension of the PPS would carry risks. We know little about why the use of posthospital care varies from state to state, and we know less about how this variation affects the costs of the Medicare program and the welfare of Medicare patients. Any major change in the mechanisms by which this care is provided and financed could risk changing the use of posthospital care, its costs to Medicare, and the quality of care in unforeseen ways. With the scanty information currently available, we cannot calculate those risks, nor the social, financial, and political consequences of a less than successful program. Only HCFA, DHHS, and, ultimately, the Congress, can decide whether the risks are worth taking.

Finally, one might suggest that while a demonstration may be desirable, the time for it is not yet ripe. We are only now beginning to accumulate systematic evidence of how implementation of the hospital PPS has affected the use of posthospital care. A major motivation for devising an extended PPS has been to counter the suspected ill effects of the incentives that face hospitals as a result of the PPS. By the end of 1986, we will be able to see whether the hospital PPS has significantly affected the use or cost of posthospital services. If it has, a demonstration might be in order. If it has not, an extended PPS may be needless.

Certainly, delaying a demonstration will allow the accumulation of better data. The new data will allow a more thorough assessment of the likely value of an extended PPS, and enable an improved demonstration design. But given that a demonstration will take several years to complete, one might wonder if more delay will eliminate the value of the demonstration altogether.

In the remainder of this report we will dispense with these equivocations and proceed as if it has been determined that a demonstration will be conducted. We will not explicitly assess its value, but we will at least make its nature more clear.

## DEMONSTRATION OBJECTIVES

The overall demonstration goal is to resolve uncertainties about:

- Economic desirability, with respect to:
  - *Medicare cost:*  
Will an extended PPS induce hospitals to use a less costly mix of hospital and posthospital services? Will these help reduce future Medicare program expenditures?
  - *Market competition:*  
Will an extended PPS promote competition among posthospital providers and hence result in a more efficient system of posthospital care delivery? Will such competition yield lower posthospital charges for the health care market as a whole as well as for Medicare beneficiaries?
- Social desirability, with respect to:
  - *Beneficiary access to care and quality of care:*  
Will an extended PPS reduce apparent access barriers to posthospital services for Medicare patients? Or will hospital efforts to control costs degrade service availability or quality?

— *Fairness to hospitals:*

Will payments to hospitals in a budget-neutral extended PPS be adequate to cover the costs of posthospital care, or will some hospitals find posthospital charges so high that the program imposes a financial hardship? Are proposed methods for computing payment levels fair to hospitals facing different market circumstances?

— *Fairness to posthospital providers:*

Will the program result in fair treatment of posthospital providers? Will hospitals provide their own posthospital care even when free-standing posthospital providers are less costly or provide superior services? Will some posthospital providers be able to profit under an extended PPS while others find that the payments offered by hospitals fall short of costs?

• Administrative feasibility, with respect to:

— *Providers:*

Will hospitals and posthospital providers be able to negotiate workable contracts specifying the prices and the characteristics of posthospital care to be provided to Medicare patients? Or will the negotiations be so burdensome that some providers will simply cease to offer care to Medicare patients? Will hospitals be able to influence physician decisionmaking sufficiently to bring about more efficient care?

— *Intermediaries:*

Will an extended PPS reduce the administrative burden borne by HCFA and by Medicare intermediaries? Will the interaction of hospital and posthospital provider interests result in a system of checks and balances that will require less intervention by intermediaries than do current arrangements? Will intermediaries be able to collect data adequate for future recalculations of Medicare payment rates for an extended PPS?

— *Peer Review Organizations (PROs):*

Will PROs find it necessary to expand or alter procedures for assuring that beneficiaries receive sufficient services of adequate quality? Will an extended PPS offer opportunities for providers to "game" the system and, if so, will PROs (and intermediaries) prove effective at limiting this behavior?



— *Medicare rules and procedures:*

How might rules and procedures for an extended PPS be refined to allow simpler, more efficient, or more equitable operation?

These objectives will require analyses based on three distinct units of observation. Issues involving beneficiary access to care, quality of care, and choice of provider require analysis of data on the experiences of individual patients. Meanwhile, questions about hospital efficiency in choosing service mix, about posthospital provider acceptance of hospital payments, and about PRO and intermediary performance should be answered using observations on the relevant institutions and organizations. Finally, market responses—forms of competition and their effects on health care pricing—will be observed for entire locales. To support the evaluation analyses, the demonstration must select participants to assure an adequate sample size and structure with respect to each of the units of observation.

## DATA COLLECTION NEEDS

Each level of analysis will require its own data collection mechanisms. It is not our purpose here to describe in detail the data that will be required for a full evaluation of the demonstration. That will be done as a part of the detailed design for the demonstration and its evaluation. Some consideration, though, of the types of data to be collected and the mechanisms that will be required to collect them will provide some insight into the magnitude of the effort involved in this demonstration.

Beginning at the most aggregate level, let us consider requirements for market-level information. These requirements are relatively minor. We will be interested primarily in establishing the amount of care in different settings that is available at the start of the demonstration and in observing any changes in these levels during the demonstration. We will also want to collect background information on the health services marketplace that may affect behavior during the demonstration; examples might be numbers of physicians or hospital beds per thousand population, occupancy rates in local hospitals, income levels, demographic characteristics, and so on. For the most part, these data can be drawn from standard sources—the Area Resource File compiled by the Bureau of Health Professionals, annual American Hospital Association surveys, and various census reports, for example. Gathering them should not be a major problem.

Provider-level analysis will be more problematical. Here we will need information on the operations and finances of particular institutions. Of interest will be such factors as numbers of patients treated, the importance of Medicare patients in overall operations, occupancy rates, provider case mix, relationships between hospitals and posthospital providers, the presence of active discharge planning, numbers of patients waiting to be transferred to posthospital settings, and a variety of financial indicators. Information on these factors will have to be gathered before the demonstration begins in order to establish a baseline and then, at regular intervals during the demonstration, to measure provider responses to the new system. Some of these data are available through regular reporting mechanisms: HCFA cost-reports and billing records and surveys fielded by provider organizations are probably the most likely sources. Other information will almost certainly require on-site data collection, in the form of examinations of provider records and interviews with and surveys of administrators. These interviews will also constitute a source of less formal information about how provider institutions are trying to adapt their behavior to the demands of the new system and about opportunities and problems the new system presents to providers. Most institution-level data collection will have to be carried out both in demonstration sites and in control sites still operating under the current PPS, so that differences in provider responses from one set of sites to the other can be noted. Detailed surveying of administrators, however, can probably be restricted to the demonstration sites.

The most difficult data collection problems will be associated with patient-level analysis. Detailed information on the cost of care will have to be gathered for patients in demonstration sites and compared with similar information gathered in control sites. Most of the necessary cost data can probably be gathered from Medicare billing records. In the interests of completeness, though, these cost data should include information on physician costs and other services not covered by Medicare Part A. A patient discharged from a hospital to "informal" care at home may require more physician services than will a patient discharged to "formal" posthospital care in an SNF or HHA setting. Medicare pays a portion of these other costs, and a full analysis of the cost implications of an extended PPS will have to take them into account. Gathering information on these additional costs will require linking information on Part A and Part B Medicare outlays. This sort of linking is probably best accomplished through access to bills submitted to local Medicare fiscal intermediaries and carriers.

Equally important with costs in evaluation will be the effects of the demonstrated system on quality of care. Any PPS provides incentives

for providers to skimp on care so as to enjoy lower costs and higher profits. An important question will be whether patients in demonstration areas receive care that differs significantly in quality from that of patients in control sites. Answering this question will require devising some way to measure the health status of a sample of patients in both demonstration and control sites at set intervals after discharge from the acute-care hospital.

Detailed analysis of quality of care and patient outcomes will add considerably to the cost of the demonstration. Health status measures have been designed for and used successfully in other studies.<sup>1</sup> These measures could probably be adapted for this demonstration, and thus save some money. But there is no way to avoid the costs, in both time and money, of applying these measures to large samples of patients. Given the importance of these considerations in the evaluation of an extended PPS, though, there seems little point in mounting a demonstration that does not allow for this analysis.

## SELECTING DEMONSTRATION TREATMENTS

To test administrative feasibility, an extended PPS in a demonstration should closely match the program that would be proposed for full-scale implementation. Some procedural deviations must be tolerated, however, to accommodate evaluation needs. (For example, an evaluation team might conduct special site visits or surveys.) And the demonstration program might differ in some minor respects from a likely national program. (For example, participants in the demonstration might receive additional payments to cover costs associated with the demonstration.) However, the general rule is that the demonstration should resemble the proposed program with respect to:

- Rules governing the extent of hospital financial liability;
- Formulas for computing prospective payment levels;
- The individuals and institutions that carry out procedures and functions; and
- Options available to providers for responding to the extended PPS.

Some variations in the design of the extended PPS are worth considering. By instituting different "treatments" (or versions of the demonstrated system) in different demonstration sites, it would be

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<sup>1</sup>See, for example, Robert H. Brook et al., "Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial," *New England Journal of Medicine*, Vol. 309, December 1983, pp. 269-274.



possible to gather additional information about the attractiveness of particular variations. Because the treatments will increase costs, however, only a limited number should be tried.

The variation most needing exploration is the extent of hospital liability for posthospital costs. A "minimalist" (as defined in Sec. IV) strategy would make hospitals liable for costs during a fairly short period of time following hospital discharge; this strategy would call for simpler liability rules and enforcement procedures, but might leave hospitals relatively insensitive to total posthospital costs. A "maximalist" strategy would make the liability more extensive, and thus would ensure greater hospital concern over posthospital costs but would also impose heavier management burdens on hospitals. Historical experience offers no indication of how the behavior of providers may vary under different degrees of hospital responsibility. The only way to explore this issue is through a demonstration that includes "minimalist" and "maximalist" strategies.

Another option is to consider making hospitals financially liable for posthospital care provided by SNFs but not by HHAs. The logic of an extended PPS proposal—that it would prevent hospitals from shifting costs to Medicare when they discharge patients to posthospital providers—suggests that the extended PPS should be fully inclusive. However, a fully inclusive system requires somewhat more complex rules and procedures, may face more political obstacles to implementation, and may not offer large enough outcome improvements to warrant HHA inclusion. Comparisons between HHA-inclusive and SNF-only treatments could provide evidence on the feasibility and desirability of HHA inclusion.

The argument against an SNF-only treatment is that its cost may not be justified by the additional evidence it produces. If HHA inclusion introduces special administrative or implementation problems, they should be observable in a carefully monitored, fully inclusive demonstration that includes both SNF and HHA care. Furthermore, if HHAs are included, we will be able to compare outcomes in sites that show variations in the availability and cost of HHA and SNF services. Thus, analysis could predict whether HHA exclusion (which reduces HHA costs to zero from the hospital's perspective) would cause major changes in use-patterns or Medicare expenditures under PPS. In short, a promising and less costly alternative to introducing additional sites for an SNF-only treatment is careful selection and monitoring of fully inclusive demonstration sites. That option is assumed in the remainder of this report.

## **X. PARTICIPATION ISSUES AND OPTIONS**

### **DEFINING PARTICIPATION**

The participants are providers and administrative organizations for whom the rules and procedures of the extended PPS will supplant existing Medicare policy during the demonstration. Participants are further categorized according to whether they are hospitals, posthospital providers, intermediaries, or PROs.

To be eligible for participation, a hospital must be subject to the current Medicare prospective payment system (PPS). Thus, for example, children's and psychiatric hospitals are not candidates for participation, but most general acute-care hospitals are. Selection of hospital participants will circumscribe potential participation in other categories. Among posthospital providers, only those that serve (or could serve) patients from participating hospitals are candidates. Similarly, candidacy among intermediaries and PROs is restricted to those whose purview encompasses participating hospitals.

It could be argued that physicians and their Medicare patients should also be considered potential participants in the demonstration. Upon admission to a participating hospital, a Medicare beneficiary's Part A coverage will be subject to the extended PPS: The hospital may provide much of the financing for the patient's posthospital care, and may collect the patient's required copayments. Patients and their attending physicians will interact with the hospital in choosing a posthospital provider and level of posthospital care, and patients may observe some changes in billing and reimbursement procedures. Physicians and their Medicare patients may also be interviewed or surveyed by demonstration evaluators. In these respects, the admission of a Medicare patient to a participating hospital automatically subjects both the patient and the attending physician to the demonstration.

However, the extended PPS has been designed to retain current beneficiary copayment liability and physician direct responsibility for patient care supervision. Physicians will be reimbursed in the usual ways and will be expected to supply posthospital treatment plans as under current policy, while Medicare beneficiaries will remain eligible for all Part A and Part B coverage to which they are currently entitled. For these reasons, physicians and beneficiaries are not explicitly regarded as participants, even though the behavior of those located in demonstration (and control) sites will be observed (through claims records and surveys) and analyzed.

It is useful to distinguish between active and inactive provider participants. A hospital may be a participant and yet make little use of posthospital care; similarly, a posthospital provider may be willing to admit Medicare patients but rarely be called upon to do so. Such inactivity would be an outcome of interest, as would abundant posthospital use. Thus, a hospital that accepts payments under the terms of the extended PPS, and a posthospital provider that agrees to accept hospital payment for Medicare patients, would be considered valid participants, regardless of how involved they are in posthospital services.

All participants would be required to provide data—or cooperate with data collection efforts—for the demonstration's evaluation. (Hospitals will provide the most data, since they are the logical collection points for medical records, revenues, expenditures, costs, and other data on most aspects of an extended episode.) Most of the data will be collected in normal Medicare recordkeeping operations, but participants would also be expected to cooperate in some special data collection efforts. (Participants could be reimbursed for costs incurred in these efforts.) In many cases, even inactive participants would be expected to provide information, because it is needed to evaluate the causes of inactivity and its contribution to market outcomes in the demonstration sites.

## MANDATORY VS. VOLUNTARY PARTICIPATION

Historically, Medicare demonstrations have been mounted on a purely voluntary basis. Often, participants propose their own programs and offer to evaluate them—or cooperate with independent evaluators—in exchange for HCFA policy waivers and financial support. In other cases, HCFA has initiated the proposals and solicited volunteers. HCFA apparently has legal authority to mandate participation in a demonstration, but has never exercised it, and any attempt to do so would almost surely face legal challenges. Certainly, voluntary participation stirs up less trouble—but will almost certainly not be adequate for a meaningful demonstration of an extended PPS.

There is also an analytical concern about voluntary participation: It can bias evaluation results. If the only organizations that volunteer are those who anticipate (and are willing to work toward) outcomes that favor themselves or their constituents, the demonstration may not reveal shortcomings that would otherwise show up.

Bias of that kind could seriously distort the outcomes of a demonstration. A hospital may volunteer because it is sure that the prospective payment increment from an extended PPS will exceed its



posthospital costs; this may occur, for example, because the hospital's patients are (or could become) unusually low consumers of posthospital services or because it exerts unusual influence over physician practice patterns. A hospital may also volunteer because it has unusually effective relationships with its local posthospital providers (which may include the hospital itself). And even if volunteers are not demonstrably unusual in these respects, the *a priori* possibility of bias might jeopardize the demonstration's credibility.

If hospital participation were voluntary, it is unlikely that all hospitals in a health care market would choose to participate, and thus could introduce bias. If a posthospital provider draws patients from several hospitals, some participating and some not, then the SNF or HHA could choose between payments under the terms of the extended PPS and conventional Medicare reimbursement by choosing among patients from different hospitals. In effect, posthospital providers could threaten to refuse patients from participating hospitals unless those hospitals were willing at least to match conventional Medicare reimbursement. This would vastly complicate the analysis of the effects of the extended payment scheme. "Saturation" of entire health services market areas will be necessary for proper evaluation of the demonstration.

Voluntary participation poses another potentially serious problem: Market effects might be concealed simply because the volunteer hospitals play a small role in their local markets for posthospital services. For example, if only one small hospital in a large urban area volunteered it would have little effect on posthospital access, prices, and use, whereas the effects might be dramatic if all the city's hospitals operated under the new plan.

Finally, sampling bias could be problematic if all hospitals volunteered in some proposed sites but not others. In that case, the concern would be that the volunteer sites would not be representative of markets in general.

There are two options for promoting hospital participation. One is to offer participation bonuses; the other is to make hospital participation mandatory in selected sites. Mandatory participation seems the only practical course.

Of course, if the bonuses were large enough, voluntary hospital participation might become universal (or nearly so) within the selected sites, in which case bias in the hospital sample would not be worrisome. And if the bonuses are large enough to bring universal hospital participation in all of the preselected sites, then the site sample could be assumed to be unbiased as well. The principal disadvantages of the bonus approach are its costs and the risk that even substantial bonuses

may not achieve adequate participation in enough sites. Moreover, some observers might question the validity of findings drawn from a demonstration that offered hospitals financial rewards for participation. Critics might argue that the bonuses made hospitals less sensitive to costs than they would be under a full-scale extended PPS that offered only budget-neutral extended payments. Again, there seems to be no alternative to mandatory participation.

Since HCFA cannot force any hospital to admit Medicare patients, "mandatory" participation would necessarily be indirect. That is, hospitals in selected sites would be denied Medicare reimbursement unless they accept the terms of the demonstration. This promises to be very effective in eliciting hospital participation because Medicare is an important source of revenue for the vast majority of hospitals. Hospitals must, nonetheless, be left free to forgo the treatment of Medicare patients if they desire. In a fully implemented extension of the PPS, hospitals could choose to refuse to care for Medicare patients. Such a development seems very unlikely, but it is conceivable, and it would be unfortunate because it would reduce the supply of services available to Medicare recipients. For that very reason, however, we must not prevent it from happening in a demonstration that is designed, after all, to warn us about potential problems with an extended PPS.

For a hospital, mandatory participation means not only that the extended PPS will be the only available form of Medicare reimbursement, but also that the hospital must accept preestablished extended payment rates. In contrast, an extended PPS would not set payment rates for SNFs and HHAs, but would permit those rates to be set by market forces. Accordingly, mandatory participation applied to posthospital providers would merely dictate that they either accept the Medicare payment rates that hospitals offer or forfeit Medicare revenues. But that is precisely the choice available to voluntary posthospital participants if all of the hospitals they serve are operating under an extended PPS. Mandatory and voluntary participation are conceptually identical with respect to SNFs and HHAs if participation is mandatory for all hospitals in each demonstration site.

As a practical matter, though, it would probably be useful to identify, explicitly, posthospital providers who will be willing to accept Medicare patients. Explicit participation by a posthospital provider would require an announcement of rates at which the provider is willing to treat Medicare patients. This rate schedule could be extremely detailed, specifying, for example, different rates for patients with different needs; or it could be rather simple, setting basic charges for all patients. It could propose fee-for-service, per-day, or per-case payments or some combination of these. All this would be at the discretion of the posthospital provider.

The purpose of such a fee schedule would be to assist hospitals in their initial shopping for posthospital services by providing them with a clear set of costs from different facilities. Hospitals and posthospital providers would be free at any time to make alternative arrangements for providing and paying for posthospital services. Announced fee schedules would apply to patients from hospitals with whom a posthospital provider had no special arrangement. Posthospital providers would be free to change their announced fee schedules in light of prevailing market conditions. An institution that initially sets its fees too high may see referrals going elsewhere and decide to adjust its fees. Posthospital providers would be prohibited from adjusting announced fees when faced with a particular patient; hospitals must be able to count on buying care for their patients at the announced prices. This might be accomplished by requiring posthospital providers to announce changes in their fee schedules two weeks, say, before they become effective.

To help posthospital providers set their initial rates and to help hospitals in their initial shopping, HCFA might provide all participating institutions with some basic information on what other payors are paying for posthospital services in the demonstration market area. Relevant information might be average Medicaid reimbursement for various SNF services, recent Medicare and Medicaid reimbursement of HHA care, and average payment rates by major insurers in the area.

We see no reason why participation by PROs and intermediaries would be problematic. These organizations operate under contracts with HCFA, which could be modified to include the administration and monitoring responsibilities necessary for an extended PPS.

## **PARTICIPANT COMPENSATION OPTIONS**

All demonstration participants will incur unusual costs in connection with their participation. Evaluation site visits, interviews, surveys, and perhaps medical record collection activities will impose costs on providers that they would not face in a fully implemented extended PPS. Furthermore, they will be expected to provide cost and other reports like those required by current Medicare policy, as well as reports tailored to the needs of the demonstration. Meanwhile, PROs and intermediaries serving demonstration sites may incur added costs if they have to maintain existing procedures with respect to non-demonstration sites within their purview as well as implement special procedures for participating institutions.



Equitable treatment of participating institutions requires that they be reimbursed for the extra costs they incur in a demonstration. Beyond this, a failure to compensate these costs could influence behavior during the demonstration so as to hinder a thorough evaluation of an extended PPS. For example, some providers might decline to participate (thereby forfeiting Medicare reimbursement) simply because data-provision costs reduce the profitability of serving Medicare patients. Even those providers that do participate may alter their behavior as a consequence of special demonstration costs; hospitals might control Medicare admissions or utilization more tightly than they otherwise would, and posthospital providers might demand higher prices to compensate for the special costs. Similarly, PROs and intermediaries might shift resources into evaluation data provision that would otherwise be available for monitoring and enforcement activities. Finally, lack of compensation might limit data quality and participant cooperation.

This additional compensation might be particularly important for posthospital providers. In a demonstration site, some of the local SNFs and HHAs might anticipate little use of their services in an extended PPS, and might therefore consider it wasteful to commit resources to devising fee schedules and providing evaluation data. If so, some demonstration objectives would be thwarted by lack of data needed to determine why some posthospital providers chose not to serve Medicare patients under an extended PPS. Suitable compensation promises to yield a more balanced, uniform, and representative sample of data concerning posthospital providers.

If compensation is paid to providers, the amounts should be determined as a lump sum, independent of the level of Medicare services actually provided during the demonstration. Otherwise, providers might alter their behavior in order to influence their compensation amounts, thus biasing demonstration results. However, the compensation level might vary among providers (even within the hospital and posthospital provider categories) if evaluation needs imply that different providers would be required to supply different amounts or types of data. For example, compensation for a provider might be based on historical Medicare patient loads.

With regard to administrative participants, compensation would be designed primarily to support reasonable resources for monitoring and enforcement, and thus should reflect a policy judgment about the desired levels of such activities during the demonstration as compared with existing policy. HCFA's experience in supporting PRO and intermediary functions would be a good guide to setting administrative compensation, once the PRO and intermediary responsibilities under the demonstration have been spelled out in detail.

## **XI. SITE SELECTION**

We argued in the last section that an entire health services market area constitutes the appropriate unit of analysis for a demonstration of an extended PPS. All hospitals within a chosen market area would be required to participate in the demonstration, and all would be subject to a single demonstration design or treatment. In this section, we address a variety of considerations having to do with sites.

### **SETTING SITE BOUNDARIES**

Conceptually, a health services market consists of a set of competing health care providers and the patients (or potential patients) who seek access to their services. In the present context, we may limit our attention to competing hospitals and posthospital providers and their patients. Our aim is to set site boundaries so that an entire episode of hospital and posthospital care will take place within our demonstration site. To the extent that participating hospitals can refer their patients to posthospital care outside the demonstration site, we will be unable to observe the nature and the outcomes of posthospital care received by these patients. To the extent that posthospital providers in the demonstration area serve Medicare patients referred from hospitals outside the demonstration area, these posthospital providers can seek to avoid the requirements of the demonstration and still maintain at least a part of their patient base. The behavior of posthospital providers under such circumstances may not be a good indication of how similar providers would behave in a universally implemented extension of the PPS. Our aim, then, is to set site boundaries that will rarely be crossed by patients transferred from hospital to posthospital care.

Geography is the most important factor influencing competition among hospitals and among posthospital providers. Distance, travel time, and travel cost are important in determining the residential areas from which providers draw their patients. Thus, a logical procedure for defining a health services market area for a demonstration of an extended PPS is to begin by identifying hospitals whose catchment areas substantially overlap, especially with respect to the residential locations of Medicare eligibles. The next step would be to identify the posthospital providers to which the selected hospitals generally refer discharge patients. If those providers serve significant numbers of Medicare patients discharged from hospitals outside the group of

hospitals originally selected, these additional hospitals and their catchment areas should be added to the candidate demonstration site and the process repeated until no new hospitals are added.

As a practical matter, the purely conceptual approach to market definition must be modified. One reason is that the conceptual boundaries are not well defined; during periods of peak demand, for example, hospitals might arrange for posthospital care at much more distant sites than during periods of low demand. Another reason is that conceptually appropriate boundaries in the context of an extended PPS may differ from those observed under current policy. (For example, an extended PPS may lead hospitals to contract with a different set of posthospital providers than are used under existing reimbursement policy.) Finally, the demonstration evaluation would benefit from using secondary data sources that do not conveniently report statistics according to the posthospital provider market area concept. Accordingly, a pragmatic approach to site definition would make use of standard boundaries.

Access to a wide variety of secondary data sources, as well as the manner in which location is recorded in Medicare data files, recommends the use of county (or similar local government unit) boundaries. However, care should be taken to assure that these boundaries are at least reasonably consistent with conceptually appropriate ones. Most demonstration sites, for example, are likely to include two or more contiguous counties. And in some instances, a potential site might be rejected because county boundaries do not align with market boundaries.

## ON USING AN ENTIRE STATE

A prominent question about site selection is whether it is desirable to apply each demonstration treatment to an entire state. The state would thus comprise a sample of county-based sites.

The advantages of selecting an entire state include:

- Availability for all sites of secondary data based on consistent variable definitions and from comprehensive sources;
- Credibility enhancement due to the size of the demonstration and the variation in local market circumstances likely to be encountered within the state;
- Reduced implementation costs due to contacts with fewer and perhaps better coordinated institutions and organizations; and
- Reduced risk that predefined site boundaries would prove inappropriate once the demonstration is under way.



However, there are also some important advantages to selecting only some sites within each state and to including sites in other states. At least with respect to SNF services, states vary considerably in the use of Medicare posthospital care, for reasons that are poorly understood. Differences among states that may affect behavior during a demonstration of an extended PPS are many: licensing procedures, certificate-of-need (CON) regulations, details of the state Medicaid program, judgments by fiscal intermediaries about covered services, and so on. Successful demonstration of an extended PPS in one or two states would not guarantee successful application nationwide. To forestall unpleasant surprises when a national system is implemented, it would be desirable to arrange for demonstration sites in as many different states as possible. It would also be useful to have control sites in the same states as treatment sites. This would allow us to observe the effects of the extended PPS without the confounding influence of state-specific factors. If an entire state were used as a treatment site, such control would be impossible. For these reasons we suggest that one entire state not be chosen as a treatment site. Instead, we should seek treatment and control sites in a number of states.

## CHOOSING DEMONSTRATION SITES

Demonstration sites should be chosen to shed as much light as possible on the factors that will determine whether a nationwide extended PPS will bring the desired gains. Ideally, one should be able to extrapolate from the demonstration experience to predict the functioning of a national system. This means that demonstration sites should reflect variations in those factors most likely to affect behavior in some ultimate national implementation.

Unfortunately, we do not know today which of these factors are most important. Among the candidates are:

- The design of the proposed extension of PPS (reflected primarily in the extent of proposed hospital responsibility for posthospital care);
- The state regulatory and Medicaid environment;
- Urban versus rural location;
- Local population characteristics including racial composition, age distribution, and recent population growth or decline;
- General local economic conditions, including incomes, employment, consumer price levels, construction and land costs, and recent local patterns of economic growth or decline;

- Health services market conditions, including physicians and acute beds per capita, hospital capacity utilization, relative costs of human and physical health care resources, numbers of SNF beds and home health agency personnel per thousand Medicare eligible, and recent changes in these conditions.

Because the number of demonstration sites will necessarily be limited, difficult choices will inevitably arise in deciding which factors to investigate most closely. If, for example, one suspected that the success or failure of an extended PPS depended most critically on the details of the proposed extension itself, one might choose sites in the same state, minimizing the effects of state regulation and allowing the effects of various demonstration designs to show through clearly. If, on the other hand, one suspected that state regulatory environments were likely to be the critical factor, one might choose to place each demonstration site in a different state. If urban/rural differences were viewed as important, one might choose both urban and rural sites in the same state, reducing somewhat the opportunity to observe effects due to state regulatory environments.

Much current attention is focused on the varying use of posthospital care from state to state. As causes, many observers site differences in state regulations and state Medicaid programs, although the mechanisms by which they affect use have never been clearly articulated. Given this concern, the most natural design for a demonstration might be to place each demonstration site in a different state, choosing states with differing current rates of posthospital care utilization and different posthospital costs. This panoramic view would minimize the chances that a subsequent national program would fail because of some previously unrecognized quirk in state regulations, programs, or circumstances. It would limit, however, our ability to identify the effects of urban or rural location or of different limits on hospital responsibilities.

These limitations are disappointing. Other studies have suggested sharp disparities in the use of posthospital care between urban and rural settings; a clearer understanding of the reasons might improve our ability to foresee the implications of a national extended PPS. No studies have examined how various degrees of hospital responsibility for posthospital care affect the use of such care. Selecting an appropriate level of hospital responsibility is a major issue in designing a national extended PPS, and evidence from a demonstration would be useful in making these decisions. It is probably not desirable, therefore, to choose demonstration sites with the sole aim of observing the effects of differences in state regulatory environments.

A good compromise might be to establish one urban demonstration site in each of, say, four states. The states would be chosen to be representative of various levels of posthospital care use in the past. Rural sites also might be established in perhaps two of these states to explore urban/rural differences. All of these sites would be subjected to the same treatment. If the effects of levels of hospital responsibility were to be explored, a few more sites could be established in the same states chosen to demonstrate the first treatment, or in additional states that have past use-rates similar to those of the states already in the demonstration. These additional sites would probably be in urban areas, since that is where most posthospital care is provided and therefore where we might be most concerned about differences between the two treatments.

Where to locate these additional sites would depend on the primary purpose of the demonstration. If it is to make as sure as possible that some sort of a national extension of PPS will not lead to disastrous consequences, then these additional sites should be placed in additional states in order to broaden the range of circumstances in which the experiment has been tried. If, on the other hand, disaster is not a worry, then the primary purpose will be to refine the design of the demonstrated system. In this case, we would prefer to have as clear a view as possible of the effects of different levels of hospital responsibilities, and this suggests placing the additional sites in the same states as the sites where we are demonstrating the first treatment.

## HOW MANY SITES?

In one sense, there can never be enough demonstration sites. The more sites, the more information. The preceding discussion suggests, however, that an absolute minimum of six sites would be necessary to examine one treatment, and eight or nine to examine two treatments.

A sample of only six to nine sites is clearly small relative to the number of variables that might be considered relevant in assessing the effects of an extended PPS. The danger in using so few sites is that they may yield vastly different outcomes, yet produce too little information to determine the causes. On the other hand, six sites in four well-chosen states should enable judgments about whether an extended PPS is administratively feasible and whether it creates socially undesirable outcomes. Additional sites would be needed primarily to estimate the economic implications of such a program, to predict the program's effect if implemented nationwide, and to reduce the chances of a surprise in a national implementation.



Additional sites may also be needed to obtain an adequate sample of patients, hospital and posthospital providers, and perhaps physicians for a full evaluation. (One such analysis might examine how an extended PPS affects the quality of patient care.) A final judgment on the total number of treatment sites must therefore await further development of evaluation analysis plans. These plans will detail procedures for hypothesis testing and will indicate how large the samples must be to attain statistically meaningful results. Findings during the remainder of the demonstration design project may suggest that nine sites are adequate for a two-treatment demonstration, or they may indicate that two or three additional sites are necessary to strike a proper balance between market-characteristics criteria for site selection and sample-size criteria for individual and provider samples.

## HOW LONG SHOULD THE DEMONSTRATION LAST?

The issue of duration calls for careful distinctions among:

- The treatment period within a site;
- The intervention period within a site;
- The monitoring period within a site; and
- The data-collection phase for the demonstration as a whole.

Within a site, the *treatment period* begins and ends on specified dates and refers to the time during which a participating hospital's Medicare discharges are reimbursed under an extended PPS rather than conventional PPS. The hospital remains financially liable for posthospital services to patients discharged through the last day of the treatment period, even though some of those patients receive posthospital services at later dates. Thus, the effects of the demonstration treatment continue for a while after the treatment period ends. This post-treatment period is included in the site's *intervention period*. It begins on the first treatment period day in any site and ends when all participating hospitals in that site have fulfilled all of their posthospital financial responsibilities under the terms of the demonstration. The intervention period is expected to exceed the treatment period by about six months in each site.

Whereas the treatment and intervention periods represent components of the treatment design, the *monitoring period* is a feature of the evaluation design. For example, a site might be monitored for a time before the treatment period begins in order to generate control data. The monitoring period might also end before the intervention period—or even the treatment period—ends.

For the demonstration as a whole, the *data-collection phase* begins with the start of monitoring in the first site(s) and ends when monitoring ends in the last site(s). Thus, the length of the data-collection phase depends on both the lengths of the sites' monitoring periods and the extent to which they overlap. Although the evaluation project will produce preliminary results during the data-collection phase, the final evaluation report cannot be completed until all data have been received. Accordingly, minimizing the length of the data-collection phase is an objective to be balanced against competing practical and analytical objectives.

### **Duration and Phasing of Treatment Periods**

The treatment period may begin earlier in some sites than in others. Sequential initiation has practical benefits: It reduces the level of effort required during the implementation phase and permits improvements in implementation procedures. The final demonstration plan might call for a lag of perhaps six months to a year between the first and last site's treatment initiation. This lag need not delay the final evaluation report if, as suggested below, monitoring periods differ among sites and the period in the last initiated site(s) is shorter than in the first one(s). The treatment period should begin and end on the same dates for all participating hospitals within a site. This would avoid confusion for the intermediary, PROs, and providers, and would greatly simplify evaluation data analysis.

Sequential initiation for the demonstration in different sites may be problematic, if the hospital PPS is undergoing major changes during this period. This is entirely possible. Questions have been raised about whether the transition to fully national rates for hospital reimbursements will be completed on the original schedule, and a variety of proposals for altering the hospital PPS are under consideration. Major changes in the hospital PPS could invalidate evidence gathered in early-starting sites and would at least complicate comparisons with late-starting sites. A decision to stagger the beginnings of demonstrations will have to be made when the demonstration is imminent and will have to be based on an assessment of the likelihood of changes in the hospital PPS that may affect the outcome of the demonstration.

In all sites, the treatment period should last at least two years. Because both hospital and posthospital utilization vary seasonally, one full treatment year is needed to generate a representative sample of utilization patterns. To determine whether these patterns change as providers become familiar with a new method of reimbursement (and perhaps as new posthospital providers enter the Medicare market), we

need to observe a second treatment year. A third treatment year in one or more sites is desirable if substantial changes are observed between the first and second years. Does the second year reflect completed adaptation to extended PPS, or has the program produced a more volatile market that might be socially undesirable? A third year of data would provide evidence to answer this question.

Unfortunately, second-year data might not be available soon enough to make timely decisions about extending the treatment period for a third year. Detailed planning for the demonstration will have to consider the possibilities for and costs of devising some means of rapidly collecting preliminary data. It may prove more attractive to include a third treatment year in all sites or simply to forgo a certain determination that adaptation to the new system is complete in all sites.

It might not be necessary to include a third year in all sites, either because major changes are found only in certain kinds of sites (e.g., large metropolitan markets) or because patterns of change are so similar across sites that one or two might be deemed adequate for testing the adaptation hypothesis. A decision to add a treatment year to test the adaptation hypothesis could be based on preliminary outcomes observed midway through each site's second treatment year.

Another rationale for lengthening the treatment period derives from interest in questions about entry or expansion by posthospital providers. Such responses take time, and their outcomes might not be observable within a two-year treatment period. (This is a special concern for SNFs because of the time that might be required to obtain Certificate of Need authorization.) Furthermore, providers facing a short-term demonstration might not make capital investments (in worker training as well as facilities) that would be recoverable if the extended PPS program were permanent. If the treatment period is simply too short to reveal entry and expansion behavior, the evaluation will not produce complete findings about the potential of an extended PPS to increase competition in the market for posthospital care.

If the demonstration is to yield information on possible expansions of posthospital service, a decision to lengthen the treatment period cannot be postponed until after treatment begins. Actual and potential posthospital providers would base their entry or expansion decisions on expectations concerning a future stream of revenues. Thus, posthospital providers need to know in advance whether the program would persist long enough to make entry or expansion investment worthwhile.

There is little evidence on which to select a treatment duration designed to elicit observations on entry or expansion behavior. A five-year treatment duration might be adequate for these purposes. This would allow as much as two years for providers to become familiar with



extended PPS and to initiate expansion activities, and still leaves three years (a typical business payback period) for posthospital providers to recoup their entry or expansion investments. Problems and delays arising from the need to obtain Certificate-of-Need approval from local authorities could, however, delay the expansion of services in some cases. It seems unlikely that HCFA would wish to commit to a treatment period in any site of longer than five years—because the hospital PPS may not remain unchanged for that long, if for no other reason. Observing long-term responses to the extended PPS will thus remain problematic. The chances of observing a long-run response might be improved if sites with an expeditious Certificate-of-Need process were chosen for five-year treatment durations. Extending the treatment period to five years need not delay the final results of a demonstration, as described below. A decision to extend the treatment period to five years in a few sites might also lessen the need to extend the demonstration beyond two years in all sites to test the speed of adaptation to an extended PPS.

### **Duration of Monitoring and Data Collection**

In any site, the monitoring period should be at least 2.5 years. This would encompass the entire intervention period in a site having a two-year treatment period. Thus, monitoring would pertain to two full years of inpatient discharges and would allow analyses of adjustment over time without confounding influences of seasonal variation. As discussed below, an additional one month to one year might be added to the minimum monitoring period for pretreatment control data collection. Obviously, a decision to extend a site's treatment period in order to examine adaptation behavior would also entail a decision to extend the monitoring period in that site.

In contrast, a decision to implement a five-year site (for analyses of entry and expansion behavior) does not necessarily require lengthening the monitoring period commensurately. The motivation for a five-year treatment is to establish a planning horizon long enough for posthospital providers to expect to recover their entry or expansion investments. For such investments to be recovered, they would have to begin yielding returns well in advance of the end of the demonstration treatment. Entry or expansion by posthospital providers, if any, should be observable in the second or third treatment year. The option of continuing the monitoring period to the end of the five-year treatment (and even through the post-treatment part of the intervention period) would remain feasible—but the demonstration plan could call for ending the monitoring period after three to four years.

Furthermore, if the five-year treatment is confined to one or two sites, the data collection phase can be kept fairly short by making those sites the first to be initiated. This is illustrated in Fig. 11.1, where the minimum plan produces a data collection phase of 3.0 years (excluding pretreatment control data collection), and an extended plan produces a data collection phase that is only one-half year longer. That additional half year would be sufficient to yield an additional full year of monitoring data in sites having a five-year treatment, and would permit examination of adaptation timing and of entry and expansion behavior in those sites.

For evaluation purposes, then, we recommend an extended plan, as illustrated in Fig. 11.1. It entails a commitment to a five-year treatment period in selected sites (we recommend two for mutual comparison), with the remaining sites committed to two-year treatments; the monitoring periods would be 3.5 and 2.5 years, respectively. The extended plan increases the overall length of the data collection phase by only six months, but promises to yield more comprehensive and representative findings concerning the market effects of a full-scale implementation. Under the extended plan, the demonstration's data collection phase would last 3.5 years from the start of treatment in the first initiated site.

## CONTROL DATA

To evaluate the effects of an extended PPS, it is necessary to estimate what the behavior and outcomes would have been in the absence of such a payment system. The data to support these estimates will come from observing control samples: selected posthospital markets, individuals, and organizations that are not subject to an extended PPS. Two sources of such data are possible. One consists of observations from the treatment sites before (and possibly after) the treatment period. The other consists of nontreatment sites observed while the demonstration is under way elsewhere. Each of these falls somewhat short of ideal. However, when used together, the two sources should provide the best basis for evaluation.

## Historical Controls

Each demonstration site will inevitably have unique features—unusual obstacles to patient travel, for example, or special historical relationships among health care providers—and no other market area will serve as a fully satisfactory control site, no matter what efforts are

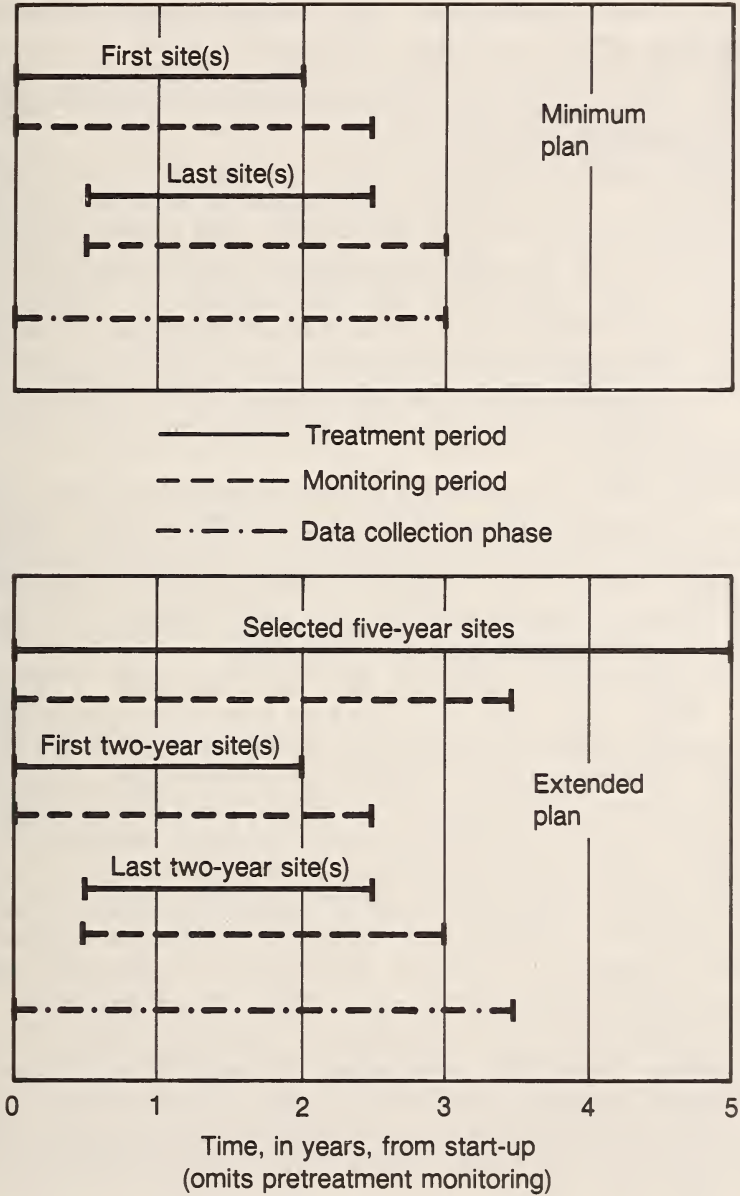


Fig. 11.1—Two options for phasing and duration



expended to find a matched site. The best way to distinguish between demonstration effects and those of site-specific factors is to use the treatment site as its own control—to make comparisons between behavior and outcomes during the demonstration with those before (or following) the demonstration.

Historical data on treatment sites are preferable to data from the post-treatment period. Historical data should be obtained for several purposes, including selection of the treatment site itself and choice of samples for surveys and other data collection efforts. Use of historical data also avoids lengthening the demonstration to collect post-treatment data. Finally, post-demonstration data might be contaminated by the demonstration treatment; for example, posthospital use might be abnormally high after the demonstration treatment ends because of demonstration-generated expansion in the number of posthospital suppliers.

The ideal body of historical data would be observations from one or two years immediately preceding the demonstration. Recent history is more likely to resemble the treatment period in all respects save Medicare policy. Even more important, recent history would reveal behavior and outcomes under the current PPS, which is the desired basis for comparing effects of an extended PPS.

Much of the desired historical data could be found in Medicare claims. While earlier data can be used for some design purposes (e.g., for the initial stages of site selection, and for part of the rate-setting exercise), the absence of PPS experience in earlier data makes them nearly useless for control purposes. Obtaining other kinds of historical data might require direct pretreatment observation in selected sites. Examples include physician and patient attitudes (if relevant to the evaluation design), formal and informal relationships between hospitals and posthospital providers, and PRO and intermediary procedures and resource use patterns. To obtain these and other historical control data, some pretreatment monitoring of selected sites is warranted.

The desired length of the pretreatment monitoring period depends on the nature of the data to be collected. If recent Medicare claims are not available, the site's posthospital use and cost patterns would have to be directly monitored long enough to yield a representative control sample; due to the seasonality concern, direct utilization and cost monitoring might take a year.

## Contemporaneous Controls

A basic shortcoming of historical controls is that they do not reflect possible changes in background factors during the demonstration. Suppose, for example, that the demonstration's intervention phase coincides with a change in the hospital PPS that somehow reduces the incentive for hospitals to discharge patients quickly; treatment sites might then show a shift toward more hospital (and less posthospital) care compared with the pretreatment period—yet the effect would be attributable to the change in the hospital PPS rather than to its extension. To control for background dynamics, the standard demonstration approach is to follow nontreatment sites over the same period of time as the treatment sites. These control sites are chosen to match the treatment sites as closely as possible in relevant characteristics.

A not mutually exclusive alternative to use of contemporaneous controls is to rely on a combination of historical controls and an analysis of general (e.g., statewide or nationwide) background trends. Some observers might consider this alternative superior because of inherent difficulties in matching control and treatment sites and because control sites add to demonstration costs. However, omission of control sites would be criticized by other observers, especially those for whom the randomized clinical trial sets the standard for analyzing treatment effects.

The use of control sites in the the present context might be fairly inexpensive. The control sites themselves can be selected from the alternates identified in the treatment site selection process described above. Medicare claims would then provide the bulk of the control data. The only direct monitoring that would be required would be the same surveys and interviews needed for the historical data on treatment sites; these surveys and interviews would be conducted contemporaneously with the pretreatment fieldwork in treatment sites and again two or three years later. The additional data collection would add marginally to evaluation costs, but automation of the analyses (which would parallel those of treatment sites) could reduce these costs. In short, we judge the modest costs of having contemporaneous control sites to be warranted by the credibility enhancement they offer, and we therefore recommend the use of control sites matched as closely as possible to treatment sites.





## Appendix A

### INCLUDING HOME HEALTH CARE IN AN EXTENDED PPS

One of the issues to be resolved in designing a demonstration of an extended PPS is whether the extended payments should cover no more than skilled nursing facility (SNF) services, or should also cover home health agency (HHA) services. The basic argument for including HHA services is that the policy should promote a more efficient mix of hospital and *all* posthospital services, including those provided through HHAs. The preliminary counterargument is that inclusion of HHAs would substantially broaden the set of administrative, political, and economic issues to be resolved,<sup>1</sup> and thus might jeopardize the demonstration project as a whole. Below, we take a closer look at the issues relevant to a decision to include or to exclude HHA services, including what is known to date concerning two criteria for judging whether home health care should be included:

- Economic desirability
  - Will HHA inclusion help control Medicare program expenditures?
  - Will it make the health care delivery system more efficient?
- Administrative feasibility.
  - Are available data adequate to design appropriate payment levels?
  - Are there problems in devising reasonable rules and regulations?
  - Are there special problems in enforcement or performance monitoring?

This appendix also discusses the effects of HHA inclusion or exclusion on the process of evaluating demonstration of an extended PPS.

We conclude that it would be premature *at this time* to exclude the HHA option, and recommend that the option remain under

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<sup>1</sup>As we noted in Sec. III, a full application of this argument might require inclusion of rehabilitation hospitals and long-term care (or chronic care) hospitals in an extended PPS. Because only very sparse information concerning rehabilitation hospitals is now available, their inclusion in an extended PPS is probably not practical in the immediate future.

consideration through the demonstration design phase. Currently available information indicates that HHA inclusion is economically desirable and administratively feasible. The design phase effort would develop more information about the option of including HHA services, and can do so at a minimal cost and without interfering with the design of an SNF-only demonstration. There is also some risk that a decision to exclude the HHA option now would be regretted later, when recovering the option would be much more costly.

Clearly, political considerations also play a role in deciding whether or not to include HHA services in a demonstration of an extended PPS. The home health industry generally opposes such an approach and would certainly make its complaints heard if an HHA-inclusive demonstration were launched. A detailed discussion of the political issues involved is beyond the scope of this report, however.

## **ECONOMIC ISSUES: COST CONTROL, EFFICIENCY, AND COMPETITION**

We first address how covering both SNF and HHA services through an extended PPS promises to contain Medicare costs and promote efficiency and competition better than an SNF-only extension of the PPS. We will develop the following arguments:

- By paying separately for HHA services, Medicare preserves a cost-containment loophole in the existing hospital PPS. The HHA loophole is probably larger than the one provided by current SNF reimbursement policy.
- Even if hospitals are not taking much advantage of the HHA loophole, pre-PPS trends in HHA reimbursement would justify interest in extending hospital payments to cover posthospital HHA services.
- Separate payments for HHA services would provide a loophole in an SNF-only extended PPS; that option could prove more costly to Medicare than the current combination of SNF, HHA, and hospital payment policies.
- An SNF-only extended PPS would arbitrarily restrict the range of competitive incentives triggered by the policy.

At present, these arguments must be somewhat speculative. Published statistics and studies offer some empirical support, but are dated

and too highly aggregated to provide adequate confirmation.<sup>2</sup> these Despite shortcomings, available evidence makes a case for continuing investigation of the HHA-inclusion option.

## Motives for Cost Containment

Medicare cost containment was a salient motive for altering hospital reimbursement policy. Between 1967 and 1983, inpatient reimbursements grew over 16 percent per year on average. In real terms, adjusting for changes in consumer prices in general, the increase in Medicare hospital payments was over 9 percent per year during this period. Since hospital payments accounted for over 60 percent of total Medicare reimbursements, control of inpatient expense had to be central in any effort to control overall program cost inflation.

In contrast, published statistics do not suggest that SNF reimbursements have been out of control. Medicare outlays for SNF services account for only about 1 percent of all Part A outlays, and outlays for these services actually declined in real terms (at an average annual rate of 4.5 percent) between 1967 and 1983. The rate of growth of these outlays has been somewhat higher in more recent years, averaging 1 percent real growth from 1980 to 1983, but remains well below the rates of increase (nominal and real) for hospital expenditures. To the extent that these data reflect a Medicare cost problem, it has not been that the utilization of SNF services has been too high, but rather that it may have been too low.

Historical data for home health services show that they too have represented a small fraction of total Medicare expenditures—but have been growing rapidly. Medicare payments to HHAs have exceeded those to SNFs since 1979 and are growing much faster. Between 1980 and 1983, Medicare outlays for home health care increased at an average rate of 41 percent per year (more than 35 percent per year in real terms). These growth rates reflect growth in home health care both following a hospital stay (and therefore relevant to the demonstration of an extended PPS) and without a prior hospital stay (care that would not be affected by an extended PPS). The requirement for a hospital qualifying stay for home health care was dropped in 1981, and the latter kind of home health care may account for the larger part of the recorded growth. From published data, it is hard to judge the size and growth rate of purely posthospital HHA reimbursements. Summary

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<sup>2</sup>Unless otherwise noted, all of the statistics cited in this appendix come from "Health Financing Trends," *Health Care Financing Review*, Vol. 6, No. 3, Summer 1984, pp. 89-98.



statistics suggest that previously hospitalized beneficiaries would account for 30 to 40 percent of total annual HHA reimbursements.<sup>3</sup> That means that posthospital HHA reimbursements exceeded SNF reimbursements by a comfortable margin by 1983.

Notably, previous changes in Medicare policies have aimed to improve access to HHA services.<sup>4</sup> It was anticipated that increased expenditures for home care would be more than offset by reductions in Medicare payments for other methods of treatment, hospital inpatient care in particular. The result has been disappointing, however; Medicare payments to HHAs have increased, certainly, but the anticipated savings in other spending categories reportedly have not materialized. HHA experience has demonstrated a potential pitfall in the strategy of trying to save money by improving access to nonhospital services. The hospital PPS provides new incentives for the use of all posthospital care. It is too early to tell how large the effect may be, but the HHA industry reports that it is occurring. For example, the National Association for Home Care reports that more hospitals are seeking cooperative arrangements with HHAs, and specifically cite PPS as causing an increase in the intensity of services required by posthospital patients.<sup>5</sup>

HHAs may be more susceptible than SNFs to increased posthospital utilization. Although Medicare access to SNFs appears to be restricted under current policies, HHAs appear to welcome Medicare beneficiaries, relying on them for perhaps half of their caseloads.<sup>6</sup> Moreover, with their low facility and equipment requirements, HHAs have an advantage over SNFs in responding quickly to enhanced demand. And while there are still some skilled nursing services that cannot be provided in a home setting, technology is rapidly closing the gap between SNF and home care capabilities.

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<sup>3</sup>In 1967, while Medicare was paying for HHA services only if there was prior hospitalization, the number of aged Medicare beneficiaries who incurred HHA reimbursement was about 6 percent of the number of aged inpatient beneficiaries. In 1983, there were 6.4 million aged persons who received hospital inpatient benefits. At a 6 percent rate of posthospital HHA use, the number of such users would be nearly 400,000, or about 33 percent of the total number of aged HHA beneficiaries. The statement in the text assumes that average HHA reimbursement per beneficiary is the same for posthospital and nonhospitalized users. Since posthospital users may have more acute needs for care, they may actually cost more. And since the number of HHAs has been growing rapidly, the fraction of patients with access to HHA services has been rising. Thus, posthospital use is probably understated by the statement in the text.

<sup>4</sup>J. L. Williams, G. Gaumer, and M. A. Cella, *Home Health Services: An Industry In Transition*. Home Health Agency Prospective Payment Demonstration, Abt Associates, Inc., Cambridge, Mass., May 3, 1984.

<sup>5</sup>*Medicine and Health Perspectives*, 1985.

<sup>6</sup>Williams, Gaumer, and Cella.

In summary, both HHA and SNF reimbursements systems currently offer loopholes in the posthospital PPS hospital cost-containment system. It is plausible to speculate that posthospital HHA reimbursements are currently more susceptible than SNF reimbursements to the PPS effect. Even before hospital PPS, HHA reimbursements were growing rapidly without offering anticipated savings on alternative sources of care. In short, improvements in both HHA and SNF reimbursement systems are warranted on cost-containment grounds, and if anything the need is more urgent with respect to home health care.

### Potential Pitfalls of an SNF-Only Extended PPS

The basic argument for an extended PPS is that in some cases, posthospital care can substitute for acute hospital care. By making the hospital financially responsible for both inpatient and posthospital care, we encourage hospitals to seek an efficient mix of both kinds of services. In some cases, home health services may be feasible substitutes for either SNF or inpatient care, and we would like to have a system that encourages efficient choices at the hospital/home-health and SNF/home-health boundaries as well as at the hospital/SNF boundary.

If HHA/SNF substitution is feasible, an SNF-only extended PPS would maintain a cost-containment loophole for hospitals. Faced with a choice between having to reimburse SNF services for a discharged patient or discharging him to an HHA reimbursed by Medicare, the hospital would perceive the latter option as financially desirable even though it would raise Medicare program expense. Even if the hospital decided that the SNF option was necessary for the patient's welfare, the hospital would have an incentive to end the SNF stay quickly by supplementing it with Medicare-paid HHA services.

What is crucial here is the degree to which SNF and home health care are substitutes for each other. Among the studies surveyed by Hammond,<sup>7</sup> several examined the relationships between extended care in inpatient and home settings. As a rule, these studies found that a portion of an extended care facility's caseload could be served in the home instead, at least for a portion of the treatment period. Notably, the studies also raised questions about the cost-effectiveness of such substitution. The survey studies did not restrict attention to skilled nursing services, to elderly patients, or to reimbursement programs subject to limitations like those of Medicare. They therefore neither prove that Medicare would experience HHA/SNF substitution nor

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<sup>7</sup>J. Hammond, "Home Health Care Cost Effectiveness: An Overview of the Literature," *Public Health Reports*, Vol. 94, No. 4, July-August 1979, pp. 305-311.

offer guidance on what its magnitude might be. They simply suggest that those matters deserve further investigation.

To gauge the potential financial effect of such behavior, consider a very conservative example. Suppose that, on average, hospitals reduce SNF stays by one covered day per stay, substituting one HHA visit. Under prospective payments extended to cover SNF care, hospitals would gain \$9 to \$10 million per year from reduced SNF payments. Meanwhile, Medicare would lose \$7 to \$8 million per year in added reimbursements to HHAs not covered by the extended payment system.<sup>8</sup> Of course, this example is purely hypothetical. Actual effects could be smaller (though not much, unless there is no substitution at all), or very much larger.

### Promoting Competition Through HHA Inclusion

In the markets for most goods and services, we rely on competition among providers to hold down costs. Under current Medicare policies, however, posthospital providers have little to gain from restraining the costs of the care they provide. Patients pay a share of their SNF costs only after the 20th day of care and pay none of their home health costs. They have, therefore, little incentive to seek out lower-cost posthospital care, and posthospital providers are not likely to attract more patients by offering lower rates. Normal competitive forces do not operate in this market.

As a substitute for these missing market forces, Medicare has traditionally found it necessary to control costs by controlling coverage of posthospital services. Sometimes this prevents utilization that would contribute to overall cost savings. For example, some of the studies surveyed by Hammond observed overall reimbursement savings when early hospital discharges were facilitated by home care programs that provided assistance in some basic daily activities. Since Medicare does not cover these services, some patients may remain in the hospital longer than necessary or may be discharged to more costly SNF settings.

An extended hospital PPS would promote genuine competition among providers, instead of merely mimicking its cost-cutting incentives. Hospitals are presumably well placed to observe differences in

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<sup>8</sup>The example is based on figures from the early 1980s, when about 240,000 Medicare beneficiaries received SNF benefits (HCFA, 1984). Average reimbursement per HHA visit was about \$30 (see C. E. Bishop, and M. Stassen, *Alternative Reimbursement for Home Health Services under Medicare*, The Center for Health Policy Analysis and Research, Heller School, Brandeis University, Waltham, Mass., June 1983). Average reimbursements per covered SNF day were about \$40 (computed from data in Sawyer et al., 1983).



the care provided by individual SNFs or HHAs and to consider whether these services constitute cost-effective care for particular patients. By giving hospitals a financial incentive to seek out cost-effective care, we also provide SNFs and HHAs an incentive to restrain their costs. Both SNFs and HHAs stand to profit by specializing in the sorts of care they provide best, and both would have to offer cost-effective alternatives to inpatient hospital care. A separate reimbursement system for HHAs would at best place HHAs in competition with each other; a fully extended PPS would induce a more robust competition among SNFs, HHAs, and hospitals.

## ADMINISTRATIVE FEASIBILITY

A demonstration tests a policy's administrative feasibility in three stages: planning, technical development, and field implementation. The extended PPS demonstration project is currently at the planning stage. Work has proceeded far enough to identify *potential* administrative issues and suggest options for resolving them. However, more remains to be learned at the technical development stage—especially through analysis of Medicare claims data. What can be said today is that no insurmountable administrative obstacles have been encountered. That statement applies to either an SNF-only policy or one that includes HHA services.

The following major points are developed in the discussion below:

- The data analysis needed to set HHA-inclusive payment rates is also needed to evaluate an SNF-only demonstration. Thus demonstration design and evaluation costs would not be greatly reduced by eliminating the analysis necessary for HHA inclusion.
- Although two shortcomings in HHA claims data pose rate-setting problems, practical options for resolving both problems have been identified and appear feasible.
- Eligibility and liability rules for SNF coverage appear straightforwardly applicable to defining eligibility and liability for posthospital HHA services.
- Changes in program operations (e.g., claims processing, quality of care monitoring) required for an SNF-only policy are essentially the same as for an HHA-inclusive one, and may function more effectively if HHA services are included.

Below we detail these points, considering three major administrative topics: payment rate-setting, eligibility and liability rules, and operating procedures.

## Setting Payment Rates

To set payment rates, Medicare claims files will be used to estimate expected posthospital reimbursements per case within DRG categories. This raises a number of important methodological questions, discussed in Sec. V. Those basic questions, and techniques available for answering them, are largely independent of whether HHA services are included in the extended PPS.

Setting HHA-inclusive payment rates will require a claims data file that collates HHA, SNF, and hospital inpatient claims for individual beneficiaries. (Since neither SNF nor HHA claims contain diagnostic data adequate for DRG designation, collation with hospital claims is essential for that purpose.) Strictly speaking, SNF-only payment rates could be set using a data file that omits the HHA claims. However, creation and analysis of a comprehensive collated file cannot be avoided simply by eliminating the HHA-inclusion option. In an SNF-only demonstration, one of the relevant evaluation questions would be whether hospitals avoid SNF expenses by increasing reliance on HHAs. To test that hypothesis, the evaluation will need data on HHA use and reimbursements during the demonstration—and comparable baseline data. Therefore, the data file and much of the analysis that could set HHA-inclusive rates would also be necessary to support an SNF-only demonstration.

Inclusion of HHA coverage does raise two issues that might otherwise receive little attention:

- How to draw a practical distinction between the posthospital (or post-SNF) HHA services for which hospitals would be responsible and other HHA services that would be separately reimbursed by Medicare; and
- Whether (and how) extended hospital payments should cover posthospital use of Durable Medical Equipment (DME).

**Defining Posthospital HHA Services.** To induce hospitals to select an efficient mix of hospital and posthospital services, their liability for different modes of care must reflect their true relative costs. For example, the policy would create inappropriate incentives if hospitals were made liable only for care directly related to the previous hospitalization when SNFs are used, but were liable for many extraneous services when HHAs are used. From the hospitals' perspective, that could make HHA care appear more expensive even if HHAs can provide SNF-equivalent care at lower costs. Unfortunately, Medicare claims data do not clearly distinguish HHA care related to a previous hospitalization. With collated Part A data, it will be possible to

determine whether an HHA claim was preceded by a hospital or SNF inpatient stay. But there is no reliable way to tell in every case whether the HHA care included some unrelated services.

SNF claims data are also potentially subject to this shortcoming. Of course, SNF claims are not reimbursable unless there is a previous hospital stay, and the dates of the qualifying stay are reported in the claims files. Nevertheless, SNF claims may cover Medicare reimbursement for services that were not strictly related to the prior hospital stays. In principle, intermediaries are responsible for denying coverage for unrelated SNF services—but in practice there is wide variation in this (and other) enforcement.<sup>9</sup> An extended PPS would suddenly create incentives for hospitals and practitioners to limit SNF use to those services for which hospitals are made strictly liable. Consequently, extended payment rates set by reference to current claims data may overstate expected DRG-related costs for SNF as well as HHA services.

This "problem" is not unlike one HCFA has already resolved in the hospital PPS. In that case, HCFA recognized that some hospital costs were for alternative placement days (hospital days caused by lack of SNF openings). HCFA could have removed those days from the cost data used to set PPS payment rates, and could then have reimbursed such days separately under SNF coverage. Instead, HCFA chose to include the alternative placement costs in calculating payment rates, but also to hold hospitals liable for those costs under PPS.

A similar approach seems sensible for dealing with posthospital payments and liability. The first step is to make posthospital HHA and SNF coverage as comparable as possible under the extended PPS eligibility and liability rules. The second step is to use existing Medicare claims data to determine what reimbursements for HHA and SNF services would have been if the new rules had applied. The resulting liability boundaries and payment levels may not be perfect (e.g., hospitals may become liable for some care that is not strictly posthospital in nature), but the resulting policy would be reasonable—and administratively feasible.

**Dealing With Durable Medical Equipment.** Claims data shortcomings with respect to DME are more severe than those for identifying relevant SNF or HHA services. In principle, extended payments that cover posthospital capital costs—including those for wheelchairs, hospital beds, and other DME—are superior to payments that cover only operating expenses. Posthospital capital inclusion would

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<sup>9</sup>Helen L. Smits, Judith Feder, and William Scanlon, "Medicare's Nursing Home Benefit: Variations in Interpretation," *The New England Journal of Medicine*, Vol. 307, No. 14, September 30, 1982, pp. 855-862.



make the extended PPS easier to administer (and monitor) since there would be no separate claims processing for capital. Capital inclusion would also create better efficiency incentives, since hospitals would then weigh the full costs of alternative service mixes.

The practical problem is that Part A claims data do not contain all the information needed to set DME-inclusive payment rates. Costs for DME provided in SNFs or billed by HHAs in conjunction with covered HHA services are included—though not separately identified—in the Part A data. However, DME costs are also reimbursable under Part B, and no one knows how much Part B DME reimbursement is related to posthospital care.

Option (1) for dealing with this problem was tentatively suggested in Sec. V. This option would simply omit DME coverage from the extended payment system. Since only Part A claims would then be used, the rate-setting exercise would avoid the costly and time-consuming task of merging and analyzing Part B DME claims. And since the Part B claims-processing system for DME already exists, this option would pose no administrative difficulties in dealing with separate DME claims.

Annual Part A reimbursements for DME are only about \$18 million, but annual Part B reimbursements are very much larger—perhaps \$310 million.<sup>10</sup> Including the Part A reimbursements for DME would have a negligible effect on the payment rates set for the policy. (Part A reimbursement for hospitals, posthospital HHA services, and SNF services reached \$32 billion in 1983.) However, since *posthospital* HHA reimbursements probably amount to somewhere in the neighborhood of \$600 million, currently, omission of related Part B DME costs could more seriously distort hospital perceptions of the cost of HHA care. It may be that little of the Part B DME costs are attributable to posthospital HHA care. Or it may be that Part B DME includes not only HHA-related equipment, but also DME used in connection with SNF services (e.g., following an SNF discharge or during temporary departures from an SNF). But if much of the \$310 million is related to posthospital HHA use, the omission of DME from the extended payment system could eliminate or even counteract the efficiency incentives the policy aims to achieve.

Although it is generally presumed that the DME omission issue is relevant only if HHA services are included in the extended PPS, that presumption might be incorrect. It is conceivable that Part B coverage for DME facilitates early discharges from SNFs or transfers of SNF

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<sup>10</sup>Williams, Gaumer, and Cella, 1984.

patients to home care.<sup>11</sup> If so, an SNF-only policy's incentives for hospitals to underutilize SNF services would be exacerbated by omitting posthospital DME coverage from the policy. Whether this potential problem is substantial depends on whether Part B DME reimbursement is commonly associated with SNF utilization—a matter that has not been examined empirically.

The only sure way to evaluate the disadvantages of a policy that omits DME is to collate Part A and Part B claims to determine how and when Part B DME is used in connection with posthospital care. Once that is done, however, it is but a small incremental step to set DME-inclusive payment levels and corresponding hospital liability. This constitutes option (2). Besides having all the desired efficiency incentives, this option would also generate useful information about the sources of Part B DME reimbursements, which are reportedly growing at 20 percent per year. The major drawback of the option is that it would expand the scope of the rate-setting process.

If that is deemed a severe disadvantage of option (2), a third alternative is available: For demonstration purposes, option (3) would simply make an informed but *ad hoc* adjustment in the payment rates to accommodate hospital liability for DME. For example, a 1 percent upward adjustment in the extended payment levels would accommodate the entire \$310 million that Medicare currently pays for DME under Part B. (The adjustment might be distributed among DRGs in any of several ways, such as in proportion to relative Part A posthospital costs.) A somewhat smaller adjustment might be used on the grounds that the \$310 million surely covers some DME that is not related to posthospital care.

The basic objective of option (3) would not be to set rates that could be used in a national extended PPS, but to implement a demonstration that would test the liability rules that appear most desirable for a national program. Demonstration experience would reveal how well hospitals can manage DME use and would gather DME use data that could then be used to set national extended payment rates. Option (3) is designed to permit that demonstration to be implemented as quickly and cheaply as option (1), but without sacrificing desired policy features.

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<sup>11</sup>In principle, Medicare reimburses SNFs for equipment and appliances the patient must continue using after discharge. However, that rule does not prevent the patient from obtaining such equipment under Part B DME coverage instead.

## Eligibility and Liability Rules

Eligibility rules determine whether a patient is entitled to health services coverage under Medicare. Liability rules determine who is responsible for paying for what part of the services. In adapting current rules to support an extended PPS, the aim is to maintain existing eligibility and patient liability conditions, while transferring direct liability for posthospital services from Medicare to hospitals. The central rulemaking task is to set boundaries for the liability to be transferred.

Under current Medicare policy, SNF reimbursement is strictly a posthospital benefit. Patients are eligible for SNF reimbursement only if they are eligible for hospital benefits, and only following a hospitalization that leads to a need for skilled services. The SNF rules are also tailored to prevent reimbursement for long-term care, even when an SNF episode is punctuated by temporary discharges. In effect, the current Medicare rules for SNF reimbursement *define* the program's concept of posthospital care. Existing SNF rules therefore establish the basic framework for extended PPS rules with regard to SNF liability: Hospitals would become directly liable for SNF services that are currently reimbursable by Medicare.

Some changes in SNF rules might be desirable to enhance efficiency under an extended PPS. In particular, current policy prohibits reimbursement for SNF care unless skilled services are needed on a daily basis. This is primarily a cost-control regulation, designed to prevent large Medicare expenditures for patients whose skilled-service needs are quite limited. However, an extended PPS is specifically designed to replace regulatory cost control with self-enforcing incentives. Even if allowed to place a patient in an SNF when daily services are not required, a hospital under extended PPS presumably would not do so unless that is the most cost-effective mode of treatment. A rule to preclude nondaily SNF care appears unnecessary. Needed instead is a rule that makes the hospital financially liable for such care.

As this example illustrates, the rulemaking task involves tailoring an existing Medicare definition of posthospital care to the special circumstances of an extended PPS. With respect to HHA services, the rulemaking task is different, and somewhat simpler. Compared with SNF rules, current HHA coverage has included posthospital care—but has not been limited to it. The extended PPS rulemaking task is thus to designate those portions of HHA coverage that will become hospitals' responsibility. The basic strategy for designing the HHA rules is to apply the SNF-related definition of posthospital care to HHA services as well. For example, a hospital would not generally be liable for



either HHA or SNF services for a patient who does not begin posthospital treatment within 30 days of hospital discharge,<sup>12</sup> or whose need for skilled services is not attributable to the prior hospitalization. (Such patients could still receive HHA benefits under separate Medicare reimbursement.) On the other hand, hospitals would be liable for skilled or rehabilitative services for a patient who is eligible for hospital benefits, has a covered hospital stay, and begins posthospital care shortly after discharge—regardless of whether the care is provided by an SNF or an HHA.

Just as some SNF rules should probably be altered under extended PPS, some HHA rules might be. One of these is the rule that HHA care should be “intermittent.” Under today’s reimbursement policies, this rule generally assures that a patient who needs daily skilled services following hospitalization will be admitted to an SNF (or receive alternative placement care)—but under extended PPS, the rule would encourage hospitals to place such patients with HHAs in order to avoid financial liability. A more appropriate rule would make hospitals liable even for daily HHA services following hospitalization, while retaining the current rule for all other HHA cases. Because current HHA policy has very few reimbursement restrictions, it is a minor task to review them for compatibility with extended PPS.

The only HHA rulemaking issue that is not quickly resolved by reference to SNF rules concerns termination of hospital liability. Section IV of this report provides two alternative limits of hospital liabilities for home health care, both of which appear to be fully feasible.

## OPERATING PROCEDURES

An extended PPS would substantially modify the current mix of Medicare administrative functions pertaining to posthospital services. There would be fewer claims to process, and much less need for regulatory oversight of Medicare coverage rules. On the other hand, an extended PPS would create incentives for reduced utilization, and so quality control (PRO and related activities) would become more important than they are now. And financial dealings between hospitals and posthospital providers might create occasional misunderstanding in which Medicare officials might become involved.

Reductions in claims processing would be much greater under an HHA-inclusive policy than under an SNF-only one. In 1983, for example, Medicare intermediaries approved more than three times as many

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<sup>12</sup>The current SNF exception for patients whose posthospital care is not medically appropriate within 30 days would also apply to HHA care.

bills for posthospital HHA services as for SNF services.<sup>13</sup> HHA inclusion would vastly increase the potential administrative cost-savings of extended PPS.

Meanwhile, HHA inclusion might not have much effect on the number of cases needing conflict resolution or quality-of-care review. Because an SNF-only policy creates incentives for hospitals to rely heavily on HHA services, other parties (patients, physicians, and SNFs) might perceive that hospitals are unduly modifying methods of treatment to take advantage of the HHA-exclusion loophole—and the perceptions may be justified. If HHA reimbursement is also covered by the extended payments, however, hospitals would not be so reluctant to use SNFs when they clearly provide a more appropriate setting for a patient.

## THE ARGUMENT FOR RETAINING THE HHA-INCLUSION OPTION DURING THE DESIGN PHASE

The best way to test the merits of HHA inclusion is to compare its performance with that of an SNF-only extended PPS. A demonstration strategy could include both SNF-only and SNF and HHA treatments. The proposal to continue designing an HHA-inclusive demonstration does not entail elimination of the SNF-only design. If, during the design project, new information raises serious doubts about the desirability or feasibility of HHA inclusion, that option could then be dropped without jeopardizing plans for an SNF-only demonstration.

Although adding a treatment to a demonstration inevitably adds to the workload for designing and implementing it, the addition is modest in the HHA-inclusion case. HHA inclusion will add very little to the data file creation and analysis work that must be done in the technical development phase to support an SNF-only demonstration.

There are several respects in which postponing further design of an HHA-inclusion treatment would substantially raise its costs. Claims data analysis that can be conducted relatively cheaply by combining HHA-related and SNF-related investigations would become much more costly if performed separately. (For example, the separate analyses might duplicate work to purge claims with anomalous entries.) Policy design efforts focused exclusively on an SNF-only option could easily introduce details that could later prove incompatible with an HHA-inclusive option, making policy revision necessary and perhaps even limiting the credibility of conclusions from an SNF-only

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<sup>13</sup>This estimate is based on 516,000 SNF bills approved and 40 percent of the 4,658,000 HHA bills approved.

demonstration. And delay of the HHA-inclusion design may promote industry opposition that might make such a policy more difficult to design and implement in the future.



## Appendix B

### OUTLIERS IN AN EXTENDED PPS

As in the present hospital PPS, there will be a need in an extended PPS to make special provision for particularly costly cases, so-called outliers. Although an extension to posthospital care would introduce some complications, the essential structure of the outlier provisions for the extended system could be much the same as those used in the current PPS.

Current Medicare regulations provide extra payments for hospitals on behalf of Medicare patients who have unusually long lengths of stay or who require particularly expensive care. A patient is designated as an outlier if his length of stay in the hospital exceeds the mean length of stay for his DRG by 20 days or 1.94 times the standard deviation from the mean length of stay. A patient is considered an outlier also if his hospital costs exceed the mean for the DRG by \$12,000 or 1.5 times the standard deviation for that DRG. Hospital days beyond the length of stay threshold are reimbursed at 60 percent of the average per diem reimbursement for that DRG (derived by dividing the standard payment for that DRG by the average length of stay). This 60 percent reimbursement rate reflects a judgment that later days of hospital care are generally less costly than earlier days. To the extent that it fails to cover the full marginal costs that the hospital incurs in providing outlier care, it also provides a continuing incentive for the hospital to discharge the patient as soon as possible. Care for patients who exceed the cost threshold is reimbursed at a rate of 60 percent also. These definitions of outliers and the rates of reimbursement for outlier care were chosen so to require an expected 6 percent of all outlays for hospital care to be devoted to outlier payments. (Early experience with the hospital PPS has shown a smaller share of outlays devoted to outliers.)

This basic structure would serve well in an extended PPS. There seems no reason to change the fraction of total outlays set aside for outlier payments or the rates at which extraordinary costs are reimbursed. Similarly, there is no apparent need to change the operation of the cost outlier threshold, although it would be necessary to recalculate the correct threshold to keep outlier payments in the new system in the desired range.

A change would be necessary in the length-of-stay threshold. Here we confront a definitional problem: How do we count a patient's total length of stay during an episode of illness when this stay may be spread across a hospital, an SNF, and possibly even recovery at home with the help of home health services? Clearly, it would not be appropriate to give an SNF or a home health day the same weight as a hospital day in identifying a particular patient as an outlier. SNF days are much less expensive than hospital days, and the financial burden on a hospital represented by a number of extra SNF and home health days is not the same as that resulting from the same number of extra hospital days. What is needed here is some sort of "exchange rate" among hospital days, SNF days, and home health days. If, for example, an SNF day costs on average one-third as much as a hospital day and a home health day one-fifth as much, one might compute a patient's length of stay in "hospital day equivalents"—the number of hospital days plus one-third the number of SNF days plus one-fifth the number of home health days. When length of stay measured in this way exceeds some threshold, the case is considered an outlier.

One technical problem may arise in defining outliers in an extended PPS. Under some definitions of an outlier, any patient receiving posthospital care may constitute an outlier. If, in addition, the underlying distribution of hospital lengths of stay and costs is sufficiently compact so that few patients who do not receive posthospital care are outliers, then the outlier payment becomes essentially an additional contingent payment for the use of posthospital care. We have argued above (Sec. III) that contingent payments of this sort were undesirable because they might encourage unnecessary use of posthospital services. This excessive use could be discouraged by making sure that this effectively contingent payment would not cover the costs of posthospital care, but in doing so we would penalize hospitals who found it legitimately necessary to transfer patients to posthospital care. A better solution would be to rework the outlier thresholds to make sure that outlier payments were not effectively contingent upon use of posthospital care. Whether or not such problems may actually arise in practice is not known at present. The analytic efforts leading to a setting of reimbursement rate for an extended PPS will provide information on the distribution of total episode costs for each DRG and will allow exploration of this issue.

## Appendix C

### SWING BEDS

This appendix considers the desirability of allowing hospitals to provide skilled nursing services to Medicare patients in so-called "swing beds" in an extended PPS. Swing beds are hospital beds whose function can "swing" from acute patient care to skilled nursing care as they are needed.

Today, in order to receive Medicare reimbursement for skilled nursing care provided in a swing bed, a hospital must have fewer than 50 inpatient beds (excluding newborn and intensive care beds); be located in an area not designated as "urban" in the 1980 census; acquire a certificate of need from the state health planning and development agency (if required in that state); have a valid provider agreement under Medicare; and meet the "Special Requirements for Hospital Providers of Long-Term Care Services." (House bills H.R. 3967 and H.R. 5111 seek to raise the maximum bed limits to 125 and 150, respectively.) As of August 1984, 273 hospitals in 31 states were certified to deliver swing bed care.<sup>1</sup> Hospitals that do not meet these requirements may be reimbursed for Medicare-covered SNF services only if they provide them in a physically distinct facility dedicated to such care and if the financial accounting for the facility is kept separate from the hospital's general accounting.

In the regulations implementing the rural swing bed program, HCFA explained why small rural hospitals would be granted the exemption to use swing beds:

While most hospitals wishing to provide a SNF or ICF level of care to their inpatients have been able to meet the distinct part requirements, small rural hospitals have had difficulty in establishing these physically identifiable units because of the limitations of their physical plant and accounting capabilities. At the same time, these hospitals frequently have an excess of hospital beds, and the communities in which they are located often have a scarcity of SNF or ICF beds in Medicare and Medicaid participating facilities.<sup>2</sup>

It seems that difficulties in establishing distinct-part SNF have not been limited to rural hospitals. The 1980 Medicare Cost Reports listed

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<sup>1</sup>*Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, Department of Health and Human Services, January 1985, p. 73.

<sup>2</sup>*Federal Register*, Vol. 47, No. 139, July 20, 1982, p. 3158.



over 6,000 hospitals, and only 488 had distinct part SNFs.<sup>3</sup> In addition, 115 out of the 243 rural hospitals that had distinct part facilities were also certified for swing beds.<sup>4</sup>

While rural areas appear to have a larger problem with SNF bed availability, urban areas also seem to have some problems. As of 1980, there were only 245 hospital-based distinct part SNFs in urban areas,<sup>5</sup> and 17 percent of the counties designated "urban" had no certified SNFs.<sup>6</sup> Even if a county does have an SNF, however, there is no guarantee that the SNF is certified for Medicare patients. One-third of all Medicaid-certified SNFs in the country do not even seek Medicare certification.<sup>7</sup> In addition, SNFs are often unwilling to accept Medicare patients because of low reimbursement rates, and because patient eligibility requirements often make SNFs uncertain as to whether particular patients will be covered.

All of these factors may create SNF shortages in urban, as well as rural, areas. In 1980 Congress legislated that all Medicare-certified hospitals could be reimbursed for SNF-level care, at the average Medicaid SNF rates, for those patients who could not be placed in certified SNFs. This seems to be very similar to a national swing bed program, but the legislation was never implemented.

## WHY ALLOW SWING BEDS IN AN EXTENDED PPS?

The primary reason to allow swing beds in an extended PPS is that because they allow hospitals increased flexibility, they may enable hospitals to manage patients' episodes more efficiently. Through the use of swing beds, hospitals would be able to transfer patients to more appropriate, less intensive levels of care even if there were no beds available in area SNFs. As noted elsewhere in this report, hospitals from different areas may not have equal access to SNF beds in placing their discharged patients. If a patient is too ill to discharge home, but no longer needs hospital level care, some hospitals are forced to keep the patient. The swing bed provision could help smooth out some of the interregional and intraregional disparities in Medicare SNF availability.

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<sup>3</sup>Report to Congress, p. 46.

<sup>4</sup>Ibid., p. 73.

<sup>5</sup>Ibid., p. 46.

<sup>6</sup>Judith Feder and William Scanlon, "The Underused Benefit: Medicare's Coverage of Nursing Home Care," *Millbank Memorial Quarterly: Health and Society*, Vol. 60, No. 4, 1982, p. 610.

<sup>7</sup>Ibid., p. 611.

Allowing swing beds in an extended PPS would also strengthen the hospital's option either to "make" or to "buy" required posthospital care for its patients. Under an extended PPS, it would presumably be a matter of indifference to HCFA whether a hospital or an SNF provides necessary posthospital care as long as the care is of adequate quality. There would, then, be no reason to force a hospital to purchase care from an outside provider if it is willing and able to provide this care at a lower cost. If hospitals have the alternative of providing posthospital care themselves, outside SNFs would be forced to compete for Medicare patients and thus might be more cost-conscious.

One could argue that most of the above benefits offered by swing beds also accrue to hospitals with distinct part facilities and thus there is no need to allow swing beds. The fact, however, is that fewer than 10 percent of Medicare hospitals have distinct part facilities.<sup>8</sup> Under current Medicare and Medicaid rules, the delivery of SNF care in hospitals has apparently been seen as a money-losing proposition. In addition, state certificate of need (CON) programs have generally restricted growth in the number of nursing homes. These restrictions generally apply to distinct part SNFs, although they do not always limit swing beds. The Department of Health and Human Services' *Report to Congress* on the Medicare SNF benefit states that an increase in swing beds would be the best way quickly to increase the number of available SNF beds.<sup>9</sup> Swing beds might be particularly important during a demonstration of an extended PPS; because the capital costs associated with establishing swing beds are low, they may provide the easiest mechanism by which the supply of SNF services could be increased in response to a new payment system.

There is also a benefit offered by swing beds that cannot be gained through a distinct part SNF. Swing beds can increase the space and resource efficiency of a hospital because the hospital is not forced to set aside a fixed number of beds for SNF-level care. The number of SNF beds could vary according to the relative demands for acute-care and SNF beds at any given time. The hospital could keep a lower inventory of total beds to address the two different needs, thus increasing the efficiency of delivering both services. If an area's total demand for SNF beds varies over time, swing beds can help smooth out intertemporal access problems.

Finally, there is a practical reason for allowing swing beds in an extended PPS. There would be nothing to prevent hospitals from reducing the level of services provided to patients nearing the ends of

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<sup>8</sup>*Report to Congress*, p. 42.

<sup>9</sup>*Ibid.*, p. 73.

their stays. An acute-care bed would thus become a *de facto* swing bed. By allowing hospitals formally to transfer patients to lower levels of care, this expected (and generally desired) behavior by hospitals would be regularized, and hospitals could be required to meet local certification standards for their skilled nursing services. More important, counting these hospital days (correctly) as SNF days would conserve the beneficiary's supply of covered hospital days.

## CONCERNS

If a demonstration allows hospitals to deliver SNF care in swing beds, the nursing home community is likely to object. Apparently, the nursing home industry is afraid that hospitals are trying to use swing beds to gain entry to the lucrative private-pay SNF market.<sup>10</sup> Currently, the SNF industry is pushing for restrictions on the existing swing bed hospitals. Legislation that seeks to limit the number of hospitals eligible to deliver swing bed care has been introduced at the state and federal levels,<sup>11</sup> and the SNF community will probably view any demonstration that looks to expand the use of swing beds as a potential threat.

States could also see swing beds as a threat to their efforts to contain Medicaid outlays. Nursing home care is one of the major costs incurred by state Medicaid programs, and states have sought to hold down Medicaid outlays by using local CON laws to limit the number of SNF beds. The rationale is that if there are fewer beds, fewer Medicaid patients can be placed. Since Medicare SNF beds are often also certified for Medicaid, states might not want to see an increase in the number of Medicare SNF beds.

There is some evidence that state CON programs have resulted in the restriction of rural swing beds. Current swing bed regulations stipulate that qualifying hospitals have to apply for certificates of need if their respective states require them. According to American Hospital Association statistics, at least 14 states currently require swing beds to go through CON approval procedures.<sup>12</sup> Hospital spokespersons have claimed that the time and expense involved in filing CON applications has discouraged participation in the rural swing bed program.<sup>13</sup>

<sup>10</sup>Kathy Fackelmann, "Hospitals, Nursing Homes Battling Over Swing Bed Program Charges," *Modern Healthcare*, April 26, 1985, p. 50.

<sup>11</sup>Cynthia Wallace, "Swing Bed Lobbying Extends to State Level," *Modern Healthcare*, April 26, 1985, p. 52.

<sup>12</sup>*Ibid.*

<sup>13</sup>*Ibid.*



Swing bed delivery of SNF-level care could also raise some quality concerns. The HCFA-sponsored evaluation of the rural swing bed experiment found that the average quality of care was lower in swing beds than in other SNFs.<sup>14</sup> Acute-care hospitals and SNFs generally have different missions and goals; thus the facilities and personnel training are often designed differently. While there is some evidence that swing bed care may improve as hospitals become more accustomed to providing SNF care, quality assurance mechanisms may be needed.<sup>15</sup> Naturally, swing beds would be required to meet the same state and federal quality standards as other hospital-based SNF beds.

The inclusion of swing beds in an expanded PPS may offer new opportunities for providers to "game" the reimbursement system. If hospitals can treat Medicare patients in swing beds, they may have a perverse incentive to discharge a patient to a swing bed early in the patient's stay. This problem would be most likely to occur under the "minimalist" approach to defining a hospital's SNF liability (as described in Sec. IV) in which the hospital is financially responsible for 20 days of SNF care. The temptation for gaming would arise in the case of a patient who is expected to need about 10 days of hospital care followed by a lengthy SNF stay. The hospital would expect to pay for 10 days of hospital care and then 20 days of SNF care. If the hospital were to transfer the patient to a swing bed after, say, only three days of hospital care, it could save itself the costs of seven days of care. Because the patient is in a swing bed, he can continue to receive all necessary hospital care. The hospital has reduced the duration of the care for which it is responsible, at the same time effectively reducing the patient's Medicare benefit. This problem is less likely to occur under the "maximalist" liability definition because the time-frame is much greater. Under the "maximalist" approach, the hospital would be responsible for paying up to 100 days of SNF care, and the hospital would be less likely to save any money through an early transfer.

Of course, under PPS hospitals already have economic incentives to discharge patients to another level of care as early as possible. But by making this transfer easier, an extended PPS and the existence of swing beds might exacerbate the situation. Currently, fiscal intermediaries (FIs) review all SNF admissions, and hospitals know that each patient's record will be examined. Thus, there is an administrative disincentive against discharging a patient too early, in addition to the

<sup>14</sup>Eileen A. Tynan et al., *An Evaluation of Swing Bed Experiments to Provide Long-Term Care in Rural Hospitals: Vol. I, Executive Summary*, Health Care Financing Grants and Contracts Reports, HCFA, November 10, 1980, p. 19.

<sup>15</sup>Peter W. Shaughnessy and Robert E. Schlenker, "Planning: Implementing New Swing Bed Programs," *Hospitals*, November 16, 1982, p. 90.

threat of a malpractice suit. Also, SNFs serve as screens because they can refuse to take patients that are not in good enough condition to be transferred to them. The extended PPS would probably reduce the first barrier; the need for FI review would be reduced since hospitals would only be admitting those patients to SNFs who they felt needed the care. The second set of barriers would be eliminated by the use of swing beds because an admission to a swing bed is really an internal transfer that would not have to be approved by an outside SNF. Some type of monitoring or regulation of discharges to swing beds would thus be needed in an extended PPS system that allowed SNF care to be delivered in swing beds.

One potential remedy is to make hospital discharges to swing beds subject to utilization review. This option goes against the grain of one of the potential benefits of the demonstration, namely the reduction of the need for the review of SNF admissions. The retrospective review of the necessity of SNF care is one of the major reasons cited by nursing homes for preferring not to accept SNF patients. It might suffice, however, to review only transfers of patients to swing beds, thus preserving most of the potential reduction in case monitoring that could be brought about by an extended PPS. This necessary review could be done by either the FIs or peer review organizations. PROs will be necessary to perform other functions in an extended PPS, such as quality control, so it may not be too much additional burden for them to also review swing bed cases.

A useful adjunct to this review process would be a limit on the types of services that can be provided in an SNF or swing bed. The intent would be to prevent the provision of hospital-level services in a setting designated (and counted for benefit purposes) as an SNF. Current regulations deny coverage for "services not generally provided by SNFs." The use of an operating room is given as an example of such an excluded service. An expansion of this concept could provide guidelines that would allow clearer limits on what services a hospital could provide in a swing bed setting. However, this approach also goes against one of the purposes of doing the demonstration. By limiting the services that an SNF can offer Medicare patients, we may lose some of the potential for treating patients more cost-effectively in an SNF rather than in a hospital.

Despite these drawbacks, the potential for swing beds to increase the efficiency of hospital operations, to increase competition in the market for posthospital services, and to even out differences in the availability of posthospital care seems sufficient to allow the use of swing beds at least in a demonstration of an extended PPS.













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